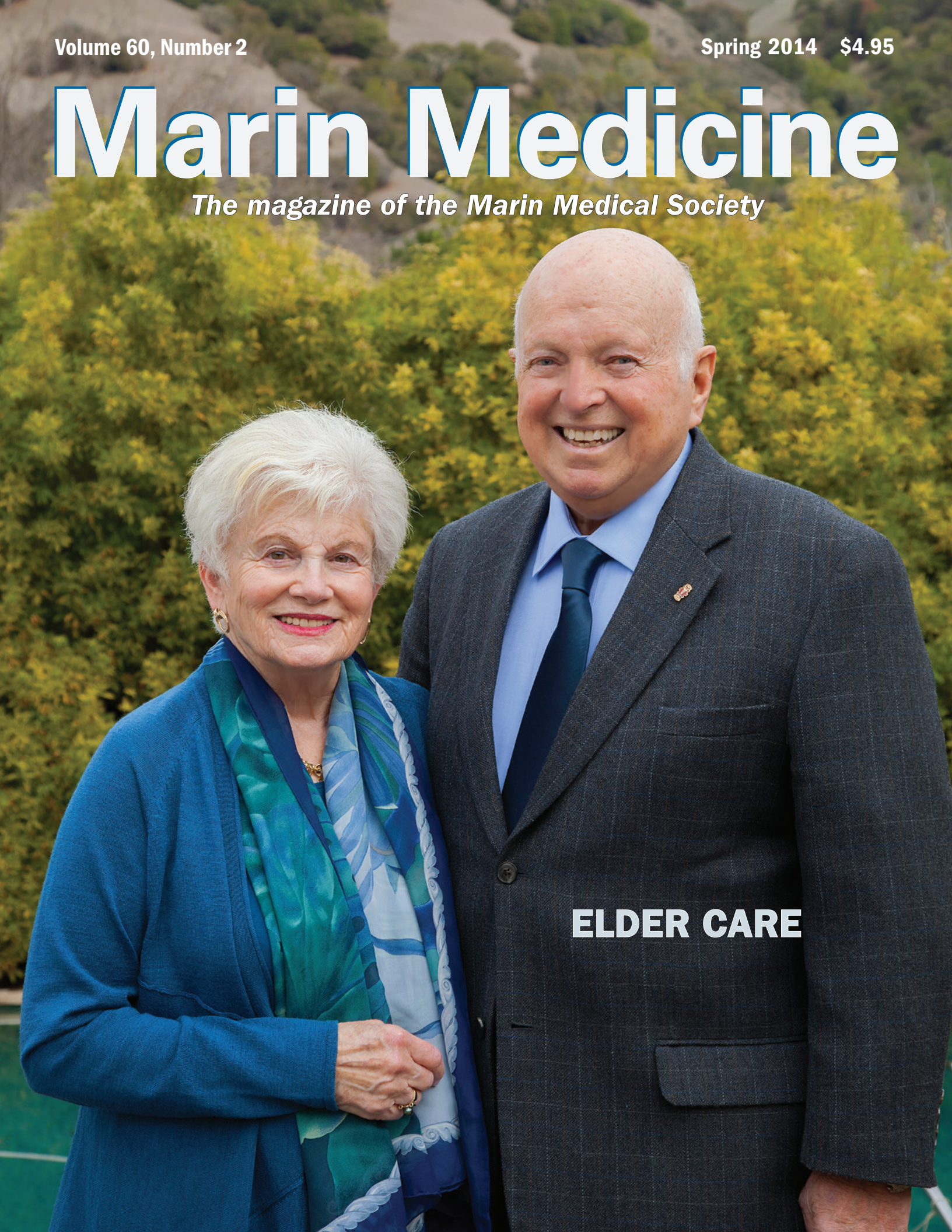
Volume 60, Number 2 Spring 2014 $4.95

Marin Medicine

The magazine of the Marin Medical Society



ELDER CARE

ARE YOU CONFUSED

BY WHAT YOU'RE HEARING ABOUT THE AFFORDABLE CARE ACT, OR COVERED CALIFORNIA? YOU'RE NOT ALONE

INDIVIDUALS

- Guaranteed issue coverage, 19 rating territories, new family component rating NEW FOR 2014!
- Is your plan grandfathered? Which ACA metal tier do you want? Do you qualify for a subsidy through the Covered California Individual exchange?
- Decide to comply with individual mandate or pay the penalty – greater of $95 ($285 per family) or 1% of household income
- Determine if you want to buy on or off exchange
- Critical to evaluate provider networks before making a change
- Evaluate formularies to make sure new insurer covers your medications

SOLE PROPRIETORS

- If you are a sole proprietor or partnership without any non-spouse W2 employees, ACA considers you individuals and no longer eligible for group coverage.
- If you have non-spouse employees, provide coverage or obtain other group coverage waivers
- If no non-spouse employees, determine if subsidy eligible for Covered California Individual plans
- Decide to comply with individual mandate or pay the penalty – greater of $95 ($285 per family) or 1% of household income
- Determine if you want to buy on or off exchange
- Critical to evaluate provider networks before making a change
- Evaluate formularies to make sure new insurer covers your medications

SMALL GROUPS (2–50)

- Does ACA require me to offer health insurance or pay a penalty?
- Is your plan grandfathered? Does it satisfy ACA metal tier standards? If not grandfathered, does the new plan include the level of benefits you want?
- No RAFs, new age bands, 19 rating territories, new family component rating NEW FOR 2014!
- Determine if eligible for employer tax credit through Covered California SHOP exchange
- Keep or consider employer provided coverage for employee morale, retention and recruitment strategy
- If no employee coverage, assist employees with meeting the individual mandate by directing them to Covered California Individual Exchange marketplace
- Comply with Employer notice requirements of October 1, 2013 for all new hires

CLEAR ANSWERS TO YOUR QUESTIONS ARE A CLICK OR PHONE CALL AWAY.

www.CountyCMAMemberInsurance.com or **800-842-3761** to speak with a Mercer Client Advisor.

SPONSORED BY:

MMS MARIN MEDICAL SOCIETY

CMA California Medical Association

MERCER

Mercer Health & Benefits Insurance Services LLC • CA Ins. Lic. #0G39709
66489 (2/14) Copyright 2014 Mercer LLC. All rights reserved.

777 South Figueroa Street, Los Angeles, CA 90017 • 800-842-3761
CMACounty.Insurance.service@mercer.com • www.CountyCMAMemberInsurance.com

Volume 60, Number 2 Spring 2014

Marin Medicine

The magazine of the Marin Medical Society

FEATURE ARTICLES

Elder Care

5 EDITORIAL
The Silver Tsunami
"The last 20-plus years have brought many changes in geriatric practice."
Irina deFischer, MD

7 LIVABLE COMMUNITIES
Aging in Marin: A Public Health Perspective
"Creating an environment where people of all ages can 'live long and live well' is an emerging public health priority."
Matthew Willis, MD, MPH

9 ACTIVE RETIREMENT
Live Long and Prosper
"For some Americans, the appeal of work extends well beyond retirement."
Steve Osborn

15 LIFE-THREATENING ILLNESS
Too Early for Palliative Care?
"Modern palliative care developed from services provided by hospice physicians and nurses, but it is now mostly independent from hospice."
Giovanni Elia, MD

18 HOSPITAL PROGRAMS
A Multidisciplinary Approach to Managing Delirium
"More than 7 million hospitalized Americans suffer from delirium each year, and more than 60% of these cases aren't recognized by the healthcare system."
Wendy Eberhardt, MD, and Clay Angel, MD

21 WORKING MEMORY
Improving Health Literacy in Older Patients
"The decline in one particular cognitive function—working memory—has a strong relationship to health literacy."
Daniel Jay Sonkin, PhD

Table of contents continues on page 2.

Cover: Dr. Filmore Rodich and his wife Judy outside their home in Lucas Valley. Photo by Duncan Garrett.

Marin Medicine

Editorial Board
Irina deFischer, MD, chair
Gail Altschuler, MD
Dustin Ballard, MD
Peter Bretan, MD
Sal Iaquinta, MD
Jeffrey Weitzman, MD

Editor
Steve Osborn

Publisher
Cynthia Melody

Design/Advertising
Linda McLaughlin

Marin Medicine (ISSN 1941-1835) is the official quarterly magazine of the Marin Medical Society, 2901 Cleveland Ave. #202, Santa Rosa, CA 95403. Periodicals postage paid at Santa Rosa, CA.

POSTMASTER: Send address changes to *Marin Medicine,* 2901 Cleveland Ave. #202, Santa Rosa, CA 95403.

Opinions expressed by authors are their own, and not necessarily those of Marin Medicine or the medical society. The magazine reserves the right to edit or withhold advertisements. Publication of an advertisement does not represent endorsement by the medical association.

E-mail: sosborn@scma.org

The subscription rate is $19.80 per year (four quarterly issues). For advertising rates and information, contact Linda McLaughlin at 707-525-4359 or visit marinmedicalsociety.org/magazine.

Printed on recycled paper.

© 2014 Marin Medical Society

Marin Medicine

The magazine of the Marin Medical Society

DEPARTMENTS

25 GOVERNANCE REFORM
CMA Envisions a New Future for Organized Medicine
"The California Medical Association is about to embark on a journey of change that will position our association as a nimble, proactive organization ready to lead the practice of medicine into a brave new world."
Steven Larson, MD, MPH

27 INTERNATIONAL MEDICINE
Report from the Tarlac Medical Mission
"On Jan. 20-24, the Philippine Medical Society of Northern California led a medical mission to Tarlac Province to help victims of Typhoon Haiyan, the deadliest Philippine typhoon on record."
Carmencita José, MD

29 LOCAL FRONTIERS
Raising the Bar for Services to Women, Infants and Children
"In 2011, MGH and the Prima Medical Group launched an innovative new maternity program involving a partnership with local ob-gyns and certified nurse midwives."
Sheri Matteo, CNM

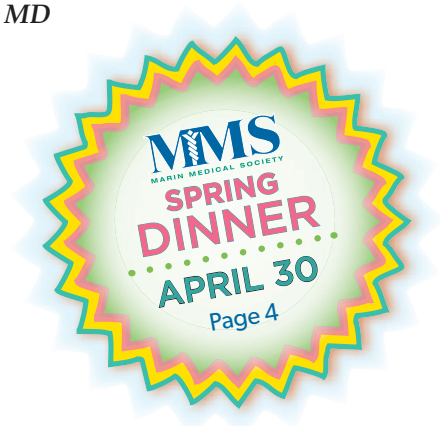
31 PERSONAL HISTORY
Reflections on a Long Career
"As I leave the world of clinical practice, I find myself reviewing our accomplishments over the last four decades."
Paul Alpert, MD

33 HOSPITAL/CLINIC UPDATE
Novato Community Hospital
"I thought I'd only be in Novato for a year or two, but I so enjoyed the hospital, the community it served and my coworkers that I never left."
Ranjit Hundal, MD

35 CURRENT BOOKS
Well Worth the Time
"If I had stopped reading *The Wonder of Aging* at this point, I would have missed out on a profoundly important book. What kept me going?"
Jeffrey Weitzman, MD

34 NEW MEMBERS

36 CLASSIFIEDS



MMS
MARIN MEDICAL SOCIETY

Our Mission: To enhance the health of our communities and promote the practice of medicine by advocating for quality health-care, strong physician-patient relationships, and for personal and professional well-being for physicians.

Officers

President
Irina deFischer, MD

President-Elect
Jeffrey Stevenson, MD

Past President
Peter Bretan, MD

Secretary/Treasurer
Michael Kwok, MD

Board of Directors
Georgianna Farren, MD
Cuyler Goodwin, DO
Lori Selleck, MD
Paul Wasserstein, MD

Staff

Executive Director
Cynthia Melody

Communications Director
Steve Osborn

Executive Assistant
Rachel Pandolfi

Graphic Designer/Ad Rep
Linda McLaughlin

Membership
Active: 350
Retired: 104

Address

Marin Medical Society
2901 Cleveland Ave. #202
Santa Rosa, CA 95403
415-924-3891
Fax 415-924-2749
mms@marinmedicalsociety.org

www.marinmedicalsociety.org

AT HOME
CAREGIVERS

Wouldn't you rather be at home?

We are a compassionate, caring team dedicated to serving those who desire to remain independent, at whatever stage of life, wherever they call home.

Monty, Chairman with Peter Rubens, Owner

From early onset dementia to end of life care, we help those who wish to stay safely at home with carefully screened and trained employee caregivers. At Home Caregivers provides assistance with shopping, transportation, bathing, dressing, and medication reminders.

Marin & San Francisco
415-898-HOME (4663)

Sonoma
707-575-HOME (4663)

"Thank you so much for the care you have provided for my mother. What comfort Peter provided me, with kindness, compassion and advice moving forward with our lives."

– Beverly Y., Mill Valley

"We are so grateful for your caregiver. She is a good cook and driver, and knowledgeable of rehab therapy, exercises, and nutrition. Her upbeat manner is delightful."

– Bea S., San Francisco

"When I needed help the most At Home Caregivers was right there for me. I can't thank you enough for your assistance in helping me recover from my broken ankle."

– Joanne R., Sonoma

www.AtHomeCaregivers.com

MMS
MARIN MEDICAL SOCIETY

All local physicians and their spouse or guest
are invited to the Marin Medical Society's

Spring Membership Dinner

featuring two presentations:

Philippine Relief Mission

Peter Bretan, MD

MICRA Update: Attacks on Our Medical Profession

CMA District X Trustees James Cotter, MD, & Peter Bretan, MD

Wednesday, April 30

6 p.m. — Social Hour
7 p.m. — Dinner & Program
Jason's Restaurant • 300 Drakes Landing Rd., Greenbrae

Tickets: **Free to MMS members**
Additional tickets $45 per person

To RSVP and identify your dinner choice, contact Rachel at **415-924-3891** or **rachel@marinmedicalsociety.org**. You can also **fax** the form below to **415-924-2749** or **mail** to MMS, PO Box 246, Corte Madera, CA 94976.

Name _____ # Tickets _____

Phone _____ Email _____

Circle payment option

Check enclosed / Visa or MasterCard # _____

Exp. date _____ Signature _____

Indicate your dinner choice(s)

___ Baked salmon with asparagus and potatoes
___ Blackened ribeye steak with spinach and potatoes
___ Brandy chicken with rice and asparagus
___ Triple mushroom gnocchi (vegetarian)

Fax to 415-924-2749

The Silver Tsunami

Irina deFischer, MD

I first became interested in geriatrics in the early 1990s, when I took the job of medical director at the Villa Marin retirement community in San Rafael. The facility includes independent living condominiums and common areas on the upper levels, along with an assisted living unit, a skilled nursing facility and a medical office on the lower level.

My practice there was similar to today's concierge practices: I had a limited panel of patients that I cared for in different settings, including inpatient hospitalization at Marin General Hospital. We had an onsite team of nurses, physical and occupational therapists, and a social worker, along with a visiting geriatric psychiatrist and a podiatrist. In 1994, I passed a CAQ exam that allowed me to "grandfather in" geriatric certification. My income was not solely dependent on Medicare reimbursement, so I was able to spend more time with patients and was enriched by hearing the stories of their accomplishments. I was inspired by their zest for life and their attitudes towards illness and the end of life.

Fast forward 20-plus years. Now I practice at Kaiser Permanente Petaluma, where I care for patients of all ages, including many seniors. Some are lifelong local residents and others have moved to the area in retirement. Some live in their own homes or with family; others in mobile-home parks, senior apartments and retirement centers; still others in assisted-living or skilled-nursing facilities. Many have limited incomes and struggle to find transportation to the office and to afford copayments and prescriptions. A number of them still work into their 80s, some as ranchers, others in retail or light manufacturing, in wineries or in hospitality. Though their circumstances may be different, they all face the same issues of normal aging and of diseases more common in the aged.

Dr. deFischer, a family physician and geriatrician at Kaiser Petaluma, is president of MMS.

The last 20-plus years have brought many changes in geriatric practice. We have made advances in treating heart disease and strokes, diabetes, cancer and arthritis, and there is a bigger focus on prevention: both by encouraging healthy lifestyles and by screening for osteoporosis and urinary incontinence, as well as reducing fall risk through exercise and balance training and avoiding prescription medications that cause dizziness or drowsiness. There has always been a concern about polypharmacy in the elderly, particularly when there are several prescribers not necessarily communicating with one another. It's a good idea to ask patients to bring in all their medications (or at least a current list), and to review them at each visit to check for duplications or medications that are no longer needed. Though there is a risk in overprescribing—especially drugs with potentially harmful side effects or interactions—there is also danger in underprescribing beneficial medications.

Team-based care and chronic disease management programs have done a great deal to improve outcomes through social support and better adherence to medical regimens. Some programs use electronic devices to monitor patients remotely. There is a growing interest in palliative care to allow patients the option of comfort and dignity near the end of life, in lieu of aggressive treatments. Advance directives are being promoted to encourage patients to consider various treatment alternatives before they are faced with a life-threatening illness.

The demographics and financing of elder care are changing as well. The number of seniors keeps growing, and their average age is increasing, which drives up the cost of care and strains the Medicare budget. Over the years, Medicare has tried several ways to reduce costs, including DRGs, SGRs, and now ACOs, which have physicians and hospitals working together to provide quality, cost-effective care. The patient-centered medical home pilot programs are also showing promise.

Thanks to our tireless advocates in the California Medical Association, Congress is on the verge of fixing the flawed SGR formula for physician payment as well as the GPCI, so payment for fee-for-service Medicare may soon be more equitable. The silver tsunami (aging baby boomers) is fast approaching, and it will usher in a new age of technologic innovations in elder care. We can already email and video-chat with patients, and there are lots of medical smartphone apps. Soon we may have robots helping with activities of daily living and perhaps even driving, and there are new treatments being developed, such as stem-cell therapy for degenerative diseases. It will be interesting to see what the next 20 years will bring! ◇

Email: irina.defischer@kp.org

OUR SPECIALIZED MEDICAL CARE INCLUDES:

- Advanced Gastroenterology
- Cancer
- Heart & Vascular
- Microsurgery
- Neuroscience
- Organ Transplant
- Pediatric Specialty Care

HELPING YOU CARE FOR A HEALTHY MARIN

Our new, state of the art MRI equipment and growing orthopedic program at Novato Community Hospital are dedicated to you and your patients. And access to our network of specialists is a phone call away. With ongoing clinical research and new therapies, our doctors partner with you to heal your most acute patients. Working together for excellent outcomes; it's one more way you plus us and we plus you.

SPECIALTY REFERRALS AND TRANSFERS
888-637-2762
suttertransfer.org

Sutter Health
We Plus You

California Pacific Medical Center
Novato Community Hospital
Sutter Lakeside Hospital
Sutter Medical Center of Santa Rosa
Sutter Pacific Medical Foundation

Aging in Marin: A Public Health Perspective

Matthew Willis, MD, MPH

In 2007, the Marin County Grand Jury used the phrase "silver tsunami" to describe the county's growing population of older adults. While it is true that aging of the county's population will have a dramatic impact over the coming decades, local communities are welcoming the challenge. At Marin Health and Human Services (HHS), we are focusing on strengthening existing community infrastructure to serve older adults while also taking action to improve the quality of life for all citizens. Creating an environment where people of all ages can "live long and live well" is an emerging public health priority.

According to the 2010 U.S. Census, the median age in Marin County is 44.5 years—the highest in the Bay Area and nine years older that the state average. Seniors are also the fastest growing age group in Marin. In 2030, an estimated one in three Marin residents will be over age 60, compared to one in four today. This is not surprising, given that many of Marin's residents are living longer than those in other counties.

Dr. Willis is the Public Health Officer for Marin County.

Last year a nationally publicized report compared life expectancy across the nation's 3,143 counties.[1] Marin women had the longest life expectancy nationally at 85.0 years, five years longer than the national average. Marin men ranked fifth for male life expectancy, at 81.4 years.

While there is plenty to celebrate, not all Marin residents enjoy a long life. When comparing certain census tracts, we find a 17-year difference in life expectancy between our healthiest and our least healthy neighborhoods. Not surprisingly, the leading cause of death in communities where people live shorter lives is preventable cardiovascular events—primarily heart attack and stroke. We also see a strong correlation between childhood obesity rates, a known contributor to cardiovascular risk, and shorter life expectancy in these same communities. In the communities where people are living longer, the leading cause of death shifts toward less preventable cancers.

For healthy aging, prevention of chronic cardiovascular disease across the age spectrum is a priority, especially among baby boomers. While Marin is fortunate to have a relatively high number of medical providers per capita, no health system is equipped to manage an epidemic of preventable chronic disease within this largest generational cohort in recent history.

This circumstance places an even greater premium on primary prevention, including opportunities to promote healthy eating through a person's entire lifespan, as well as age-appropriate fitness programs and recreational facilities that offer convenient, free and safe options for physical activity. One in four Marin County adults is obese, and one in 10 is a smoker. There is plenty of opportunity to ensure that more people can "live long and live well." The county-wide Healthy Eating and Active Living Initiative (www.marinHEAL.org) is currently bringing together residents and community partners to create a roadmap for improving community health.

For medical providers, perhaps the most important trend to consider is increasing rates of dementia. Among Marin residents over age 85, Alzheimer's is now the third leading cause of death. A general shortage of geriatric providers and too few students entering geriatrics as a profession are causes for concern. It will be critical for non-geriatric clinicians to understand issues of dementia, including early detection and how to support patients and their families.

According to the Alzheimer's Association and the CDC, one in eight adults age 60 and older reported experiencing "confusion or memory loss that is happening more often or is getting worse" over the past year.[2] Among these individuals, only 19% reported discussing these changes with a healthcare provider. Other studies have found that half of those who meet the diagnostic criteria for dementia have not received that diagnosis from a physician.[3,4]

Fortunately, medical providers can find support for their aging patients from several local programs and efforts.

Project Independence, operated by HHS, is a nationally recognized program that provides a bridge of support for people transitioning from hospital discharge to independence at home. Outreach and home visits have helped reduce the rate of recurring hospitalizations to 6% in Marin, compared to 20% statewide.

Financial Abuse Specialist Team (FAST) is available to assess elders who may be at risk for being taken advantage of financially. For more information about FAST, and any other services for older adults, visit the HHS website at www.marinhhs.org/aging-adult-services. To make a referral, call 415-457-4636.

Marin County Prescription Drug Misuse and Abuse Initiative is currently engaging stakeholders county-wide to address prescription drug misuse for all age groups, including seniors. The number of narcotic pain medications being prescribed in Marin County has more than doubled in the past 10 years, and there has been a corresponding increase in overdose deaths. In addition, opiate pain medications and benzodiazepines increase fall risk in the elderly.

Skilled nursing facilities will become a larger fraction of the healthcare system for those who may not be able to live safely at home. HHS is strengthening relationships with Marin's 14 facilities to prevent disease, especially through infection control. The facilities now report staff and client influenza vaccination rates; in-service training is offered to facilities with low rates. This intervention helped increase staff vaccination rates from 58% in the 2012-13 flu season to 90% in 2013-14.

Senior Villages have emerged in Marin. These virtual communities respond to the changing needs of the growing older adult population. They are typically nonprofit organizations that assist older adults in performing daily life tasks they can no longer do themselves. To learn more, visit www.marinvillages.org.

The increase in older adults presents an exciting challenge for Marin County. Medical care is one component of a "livable community" that includes appropriate and affordable housing, adequate mobility options, safe and open spaces, opportunities for civic engagement, and access to health and social services.

Service assessment and development is a continuous process, and medical providers have an important voice in shaping policies and programs to meet the needs of our older residents and their families. Community input is essential. Marin County welcomes citizen involvement on the Commission on Aging, which advises the Board of Supervisors and HHS on issues related to older adults in Marin. For more information, or to volunteer, visit www.marinhhs.org/boards/commission-aging. ◇

Email: mwillis@marincounty.org

References

1. Wang H, et al, "Left behind: widening disparities for males and females in US county life expectancy, 1985-2010," *Population Health Metrics,* 11:8 (2013).
2. Alzheimer's Association & CDC, "The Healthy Brain Initiative," Alzheimer's Association (2013).
3. Boustani M, et al, "Screening for dementia in primary care," *Ann Int Med,* 138:927-937 (2003).
4. Bradford A, et al, "Missed and delayed diagnosis of dementia in primary care," *Alzheimer Dis Assoc Disord,* 23:306-314 (2009).

hear today, hear tomorrow

Specializing in: Diagnostic and Industrial Audiology, Balance Care Program, Tinnitus Care Program, VNG, ABR/AABR, OAE, Individual Communication Needs Assessment, Digital Hearing Solutions, Lip Reading/Listening Skills Training, Hearing Assistance Technology (HAT) for TV, Telephone, Music and T-Coil Looping, and Auditory Mapping MA⁵P™ Method for the prescriptive/individualized fitting of hearing aids.

30 YEARS
AUDIOLOGY ASSOCIATES
SINCE 1984

Peter J. Marincovich, Ph.D., CCC-A
DIRECTOR, AUDIOLOGY SERVICES

Judy H. Conley, M.A., CCC-A
CLINICAL AUDIOLOGIST

Toni Iten Will, Au.D.
CLINICAL AUDIOLOGIST

Convenient email access to hearing healthcare providers.

VISIT DR. MARINCOVICH'S BLOG
drpetermarincovich.com

See our website for more information at audiologyassociates-sr.com

AUDIOLOGY ASSOCIATES

a member of AUDIGY GROUP

FOUR OFFICES SERVING THE NORTH BAY **TOLL FREE: 1-866-520-HEAR (4327)**

NOVATO
Novato Audiology Assoc.
1615 Hill Road, Suite 9
(415) 209-9909

MILL VALLEY
Mill Valley Audiology Assoc.
591 Redwood Hwy., Suite 1210
(415) 383-6633

SANTA ROSA
Audiology Assoc.
1111 Sonoma Ave., Suite 316
(707) 523-4740

MENDOCINO
Mendocino Audiology Assoc.
45080 Little Lake Street
(707) 937-4667

Live Long and Prosper

Steve Osborn

For many Americans, the key element of their retirement dream is never having to work again. No more days rising at an unspeakable hour, wolfing down breakfast, commuting in maddening traffic, suffering through meetings, completing mountains of paperwork, enduring relentless stress. Instead of all that, the retirement dream promises days filled with leisure, traveling to distant lands, playing cards and tennis, eating luxuriant dinners—even moving to a retirement community where the sun always shines.

Not everyone thinks that way, however. For some Americans, the appeal of work extends well beyond retirement. Many doctors, for example, seem to have medicine in their bones and continue to practice in one form or another even after officially hanging up their spikes. Two such doctors live right here in Marin County: Dr. Marjorie Belknap and Dr. Filmore Rodich. Both "retired" at the usual age, but each one has stayed remarkably active in the decades since, not only with medicine, but also with community involvement and an enduring curiosity about the world.

To learn more, Marin Medicine *interviewed both doctors earlier this year, letting them describe active retirement in their own words.*

Marjorie Belknap, MD

Dr. Marjorie Belknap, 88, had a practice in internal medicine in Marin County from 1955 to 1987. Born in Denver, she grew up in Southern California and received her MD from Stanford University, where she also completed her internship and residency. Since retiring, she has been actively involved with many nonprofit organizations and government agencies, including the William Babcock Memorial Endowment, the Marin County Commission on Aging, and Senior Access. She recently moved to The Tamalpais, an active retirement community in Greenbrae. The following interview was conducted at The Tamalpais on Feb. 5.

How do you keep yourself physically active?
Well, over the years that has changed from time to time. After I retired I played a lot of golf because I had more time. And I played some competitive golf too. But I gave that up a couple years ago. I gave it up because it took too much time away from other things that I was doing. But I have been a hiker and a walker for a long time, so that is mainly what I do now.

How many hours a day do you walk?
I try to do that one or two hours a day. I also do birding—I go out to some of the bird refuges in California for birding.

Do you keep a birding book?
No, I'm not one for keeping records of things. I just remember what I've done. But these are often birds that are migrating, including waterfowl.

I think the most interesting one, because of its behavior habits, is the sandhill crane. They're big birds! They spend the winter down here in the valley. They're fascinating because of their behavior.

What's so unusual?
They usually gather in family clusters, so there may be three of them pretty commonly together: the male, the female and the youngster. But the youngster is born up north of here, and by the time November or October comes, that bird has to be big enough and strong enough to fly down to the Sacramento Valley. So it is really fully grown in just a few months, and it's just fascinating to watch these family interactions with the dances and other rituals.

Do you have any artistic pursuits?
I used to do some painting, but mainly I've done photography in the last few years. You may have seen some of the pictures here. But I don't do very much of that right now. I'm in kind of a transitional phase.

So what are you transitioning from?
I am changing from a whole lot of demanding volunteer activities, and some of the professional things I did, into more of a life of leisure. And more concentrated probably in this area. Not so much in the community, but more here where I'm living.

I know you have been involved in many nonprofit organizations. Can you talk about the ones that you were in when you first retired, and then where you are now?
Well, I went through a period where I didn't do much. I was closing my practice and doing some part-time work at Marin General Hospital. And then

---

Mr. Osborn edits Marin Medicine.

Dr. Belknap in front of her apartment window at The Tamalpais. *Photo by Duncan Garrett.*

after a little while, I got a little more involved because I found out that I didn't want to do just part-time medical work. So this is when I got more involved with more volunteer and more nonprofits. I was a member of the William Babcock Memorial Endowment board of directors. And I did that for several years. And then the Marin County Commission on Aging, which I did for a very long time and was chair of that twice. I just went off of that in July.

What does the Commission on Aging do?
It advocates for older adults over the age of 60. It is a federally qualified commission, and that means that it is funded primarily by the Older Americans Act that comes out of Washington. We fund educational and informational programs, and we partially fund the nutritional program. The Whistle Stop delivers home-delivered meals under this program. We are also advocates for senior housing, transportation, and other support services for low-income folks who may not have access to some of these services in the county. So it is a pretty active program that many people do not know about.

And do you feel you were able to accomplish something?
Oh, yes, I think it does a lot of good. I think there is a lot more that could be done, though, but we don't have money for it.

Were there any particular programs that were close to your heart?
One was the Health Committee. I was chair of that under the Commission on Aging. I was chair of several committees. I just like the whole program. It really takes in the whole county, and things that have to be done identifying needs of older adults.

Are you still involved with other volunteer activities?
I'm president of the board of directors of Senior Access, which is a daycare program for folks with memory loss: that's a euphemism for dementia. It's really an interesting program. They have an outing program, which takes some of these people out to interesting places all day, and they have lunch: museums, the Bay Center, all kinds of places. They also have a program in San Rafael where they do artwork and have music, and they do exercises and so forth. These are people that need some assistance with their living arrangements, but they also have caregivers who get worn out. So this is a support program for them, too.

One hears that caregiving is very stressful.
It is! It is a huge and increasing problem in the county.

Any other volunteer activities?
That's mainly it. I do some activities with the Bioethics Committee at Marin General Hospital, and I just recently resigned from the Biological Safety Committee at the Buck Institute, which was kind of interesting, but I didn't have enough time for it. I've tried to pare down what I'm doing.

We've talked about your physical and artistic pursuits, and your volunteering. What about your mental activities in general?
Well, let me tell you, dealing with nonprofit organizations is a challenge. I kept my medical license until May, so I had all of the continuing education requirements for that. And that was because one volunteer activity required that I have an active license, and I was medical director of the Adult Day Healthcare program in Novato, and that also required that I have a license. I was also working here as a consultant and at Kentfield Rehabilitation Hospital as a consultant on a part-time basis. So I kept up the medical part without having to do direct patient care. I worked with physicians and nurses on those programs.

So you have really been extraordinarily active! Do you miss practicing medicine itself?
I miss the patients, but there are a lot of other things I don't miss about it. I was a solo practitioner, and this was very demanding because you didn't have too much extra time, although I was able to collaborate with other solo practitioners to take calls. I don't miss having to be on call at night or on weekends, and I don't miss the business part of it. I left medicine at about the time things got really complicated, so I was fortunate to be able to quit then.

Do you find that retirement gives you more time for friendships to deepen?
Oh, sure! That's part of friendship. It takes nurturing, and that means time. The people I've met around here are extraordinary, I can tell you. It's an amazing group that lives here. There are people who have had varied professional and/or personal lives, who are willing to share them. It is a whole new experience.

So it's a different social group.
Yes, a different social group. When I retired I found that joining a golf club gave me a whole different social group. People I never would have known. And they were interesting, and some of them have remained friends over the years. And some of them, you know, it was golf only. And then when I got on the Commission on Aging, I found that it was an extraordinary group of people, and people I never would have met otherwise. And some of them became friends. So everything that I've done has opened up new gates to different groups and different kinds of groups of people.

It sounds like retirement has really allowed you to enter these new worlds.
Oh, yes! Several different new worlds! And they're all what you make of them. Not too long ago I was at a party with one of my colleagues who was getting ready to retire. And I said, "What are you going to do?" And he said, "Well, I don't know!" And I said, "You know, you really ought to have some kind of a plan of what you're interested in doing." And he just shrugged.

Did you have a plan when you retired?
I did, I had a plan.

And what were the key elements?
Well, the key elements were that I wanted to do some part-time work, which I was able to do, but I also wanted to do a lot of the things that I hadn't had time for.

Are you happier than when you were practicing medicine?
No, I never was particularly unhappy. I think happiness is enjoying what you're doing, and I enjoy what I'm doing right now. I may go and do something different six months from now. I don't know, but I'm open to suggestions! The thing is that I never wanted to have people too interested in how old I was. When you get to a certain age, a lot of people think that you're not able to do certain things. I come from a very long-lived family. I figure that as long as I'm capable of doing these things, nobody has to know that I'm as old as I am and say, "I don't know how you do it!" It isn't how I do it, it's just me. You make of life what you're capable of doing.

What would be your advice to physicians who are nearing retirement? How do you think they should prepare for it?
I think it is really important to do it with the right attitude. I did it because I wanted to retire. I think some do it because there is some pressure to have them retire, either health conditions or whatever some of the other issues are. And I think they're at a disadvantage, I think you really have to want to retire. I look back at my father who was 74 before he retired—he was a small-business man. And he decided at 74 he wanted to retire. He never wanted to retire before that. I think that's an advantage, whatever your reasons are, that you really want to retire.

Have you had any experience since you were retired that made you say, "Oh, this is what retirement is all about"?
I don't ruminate very much. I just take life as it comes, and I enjoy it. Some days I don't know what I'm going to do yet, but I find something to do.

Was there any time where you were particularly happy or ecstatic?
That's kind of hard to say, looking back, because I've never been unhappy; I've always been satisfied with what I'm doing. There was a period where I was conservator for a good friend who had been a patient of mine. And I thought, I'm so happy that I can do this for her. And she wanted me to do it, and she was not capable of handling her own affairs. So I did that for a couple of years, and that was very satisfying, really, to be able to do that for someone who wanted me to do it.

Filmore Rodich, MD

Dr. Filmore Rodich, 81, practiced internal medicine full-time in Marin County from 1963 to 2003. He was president of the staff at Marin General Hospital from 1981 until 1983. Born in Minneapolis, he received his MD from the University of Minnesota, followed by an internship at the U.S. Public Health Service Hospital on Staten Island and a residency at the Mayo Clinic in Rochester, Minnesota. He also served two years in the U.S. Air Force at Travis Air Force Base. After retiring, he continued to serve as a medical examiner for the Federal Aviation Administration (FAA) and began working part-time on the medical staff at Villa Marin, an active retirement residential community in San Rafael. Dr. Rodich and his wife, Judith, live in Lucas Valley, where they raised their three children. The following interview was conducted in his Villa Marin office on Jan. 7.

Could you give me a general description of what your job entails? How does it compare to your former practice?

I don't have to make hospital rounds, so when I come here I make rounds on the personal care unit and the skilled nursing unit. Then I come to my office, and I have an appointment schedule for the rest of the morning. Patients or residents who want to see me about various problems can come down to my office. I have about two or three hours of outpatient visits. There are 210 condos here, so there are about 350 people. They are all seniors, and they do get sick. We provide a fair amount of medical practice for our senior citizens, who are into a phase of life where they require a little more care.

Are the outpatient office visits basically the same as when you were in practice?

Yes, that's what I love about this job. I practice medicine, see a lot of pathology, and make a lot of diagnoses. I think we help our people.

What about the business aspect? When you had a private practice, I assume you were running it and dealing with the insurance companies and all that.

Yes, we had business meetings and dealings with personnel and many other issues. We don't have any of that here. I am basically an employee, and so the administration is out of my hands. I am perfectly happy to yield that responsibility to others. I just practice medicine, which is lovely.

You also work part-time as an FAA examiner, which you've been doing for 45 years. What does that job entail?

The FAA requires that pilots have periodic medical exams. An airline captain has to have an exam every six months, and the pilots who are not captains but have senior flying positions get a Class II, which lasts for a year. Pilots who are over 40 need a Class III exam every two years. It is up to the pilots to engage an FAA medical examiner.

The FAA certifies me as being a qualified medical examiner, but it's up to the pilot to make an appointment and pay me for the exam. So it is a private practice, and I have a steady group of pilots who have been coming to me for years and years. It is a very pleasant practice because it is like greeting old friends. It's a responsible job, but it's a pleasant job because most of the pilots are pretty healthy and are good people.

You also volunteer for the RotaCare Clinic. How often do you do that?

It is a three-hour stint once a month. Kaiser, to their great credit, donates the third floor of their clinic in downtown San Rafael on Monday and Thursday evenings from six to eight. They donate that time for the clinic physicians to see people who have no insurance, so it's a free clinic. The Rotary Club provides the medications; the nurses, interpreters, pharmacists, and doctors volunteer their services.

Do you have any trouble recruiting volunteers for the clinic?

They are always looking for more volunteers. They are trying to expand and provide another night, so they need more doctors. When we arrive, that waiting room is full, so we have to take care of quite a few patients. It is a very pleasant clinic—there is camaraderie with the other volunteers, and the patients are very appreciative.

What else are you doing in retirement? Do you play any sports or travel?

My wife likes to travel, so we do a little traveling. I am not a golfer, and I don't own a boat. We don't have a gardener, so I take care of our place in Lucas Valley. I do the minor repairs and all the gardening, so that takes up some of my time. My wife and I are attending adult classes sponsored by Dominican University and the Osher Lifelong Learning Institute. I am enjoying this phase of my life a lot because I have some free time and yet I am still involved with practicing medicine.

I was raised by my widowed mother, and she taught me that life is not a game: it's not golf or play, it's work! So over the years, I have enjoyed the structure of having to show up for work and having a schedule, and I like doing what I'm doing. I'm blessed to have been able to become a doctor because it has been a very enjoyable career, and I still like doing it. To me, it is not a chore, it's not work. I am not one of the doctors who was dreaming about retirement over the years and just couldn't wait to get out of the office. I liked my practice and my colleagues in medicine. Practicing medicine is a privilege, and it's wonderful.

And you are still able to do the work that you enjoy.

Yes! People ask me how long I'm going to continue practicing, and I say truthfully—as long as I keep making sense, I want to keep working. The older doctors were trained in a different time, when we didn't have the wonderful tools available today, like CT scans and MRIs. We are more comfortable just taking care of people with a stethoscope and our hands-on experience. Here at Villa Marin, we are able to get labs and x-rays, but CT scans and MRI exams are available at outside labs.

Has your attitude toward life changed at all since you retired?

When I was in practice, I was always crusading for something, and we faced all kinds of issues. Mostly, I feel blessed that we practiced medicine at a time when it was really fun to practice, but we had our problems too. There was a time in the 1970s when all of the malpractice insurance companies left California. One of my partners had an RV, and he took a group of us up to Sacramento to join others who were petitioning for a cap on compensation for pain and suffering, which was achieved and brought down the cost of malpractice insurance in California. When I was an officer of the staff, I often found myself in the midst of battles. Even though I am interested in politics, I am less combative than I used to be. I'm mellowing a little bit.

Are there any other changes you have noticed?

No, I'm resisting all these changes. I don't want to be a grumpy old guy! You know, the computer came along, and with a young family I decided to get familiar with the new technology. The FAA now requires me to do my reporting online. I'm not an expert on it, but I'm adequate on the computer, and I love my iPhone.

I see you holding it right there. That's a pretty recent model.

I used to have an old, complicated program for obtaining medical information. I dumped all that, and I go to Google. Google knows everything. If I have a question about a medicine that has a generic name that I don't recognize, Google tells me what it is, and gives me the information immediately.

So you are pretty current on all the technology?

Well, I am not an expert, but I love it. I am trying to do more and more, and I find it extremely helpful, especially with drug interactions. If I'm dealing with 80 or 100 drugs that I use and try to see what the interactions are, I get 10,000 combinations, and it's impossible! Google knows interactions that a human can't know. We know some of the famous ones, but we can't know them all.

What would your advice be to physicians nearing retirement?

I actually gave a colleague some advice one time, and it worked. His office was located across the hall from mine. He called me in to tell me he was retiring and was moving to Scottsdale. So I said, "Why the hell do you want to do that? If you are in Marin County, you will always be Dr. X. If you go to the store, or to a restaurant, or you're on the street and you meet your old patients, you're Dr. X. If you go to Scottsdale, you're just another old guy with gray hair, and you're going to get lost there. And you don't want to do that." He thought about it, took my advice, and didn't move! He has been very active and very grateful that he stayed in the community.

My advice to myself was that if I did something terrible and my name and picture got on the front page of the IJ, I would move to Scottsdale. But as long as that doesn't happen, I will stay here, and when I go to Costco, where I often see my former patients, we will hug each other and reminisce. So my advice is not to move but to stay right here. Marin County is a great place.

I think it's wise for retirees not to be too far from a medical center. Having UCSF across the bridge is critical. Your local hospital can do most things, but when you need something special, you need a medical center like UCSF that can do everything. The technological advancements that are available in modern medicine are so unbelievable that if you get to the right place you can be cured.

Do you have any other thoughts that you would like to share with our readers?

There are doctors who discourage people from going into medicine. I have never done that. I think medicine is a privilege and that it will survive the hassles it is now confronting. This is not the end of medicine. Good medicine will always have value, and people will find a way to get good medicine. I don't know what medicine will look like in the future—it won't be like it is now—but doctors will be rewarded for their skills. Your life without your health is not worth much. ◇

WE'RE PROUD OF THESE NATIONAL HONORS, AND HONORED TO TAKE CARE OF MARIN.

Accredited Breast Imaging Center of Excellence

Society of Chest Pain Centers Accreditation

The Joint Commission's Gold Seal of Approval™ for the hospital, behavioral health services, as well as advanced certification as a Primary Stroke Center.

Commission on Cancer®

3-Year Accreditation with Commendation & Outstanding Achievement Award

Marin Cancer Institute became one of only 106 cancer centers nationwide (out of approximately 1,500) to receive the American College of Surgeons Outstanding Achievement Award, and received a perfect score in all eight areas of measurement.

The American Heart Association and American Stroke Association recognize this hospital for achieving 85% or higher adherence to all Get With The Guidelines® Stroke Performance Achievement indicators for consecutive 12-month intervals and 75% or higher compliance with 6 of 10 Get With The Guidelines Stroke Quality Measures to improve quality of patient care and outcomes.

World-class care, right here at home.

We are thrilled to have earned recognition for the high quality care we deliver. A few of our recent accolades include reverification as a Level III Trauma Program, and receipt of the Get With The Guidelines® Stroke Gold Plus Quality Achievement Award for the third year in a row. And in the past year, we were recognized by Blue Shield of California as a Blue Distinction Center in the fields of spine surgery and knee and hip replacement. Our physicians and staff were recognized by national organizations for their service, as well as for their contributions and research in oncology.

We thank the dedicated staff and physicians who have made these achievements possible. We will continue raising the bar to deliver the health care the people of Marin County deserve.

MARIN GENERAL HOSPITAL

1-888-99-MY-MGH (1-888-996-9644)

OUR HOME. OUR HEALTH. OUR HOSPITAL.

Too Early for Palliative Care?

Giovanni Elia, MD

"It's too early for palliative care," said the critical care specialist, pointing at the patient in Room 11 as we were making rounds in the ICU. "She wants everything done!" he continued. The patient was a 67-year-old woman with metastatic ovarian cancer admitted to the ICU for pneumonia, pleural effusion and respiratory failure.

This episode illustrates a much-too-common misconception of the role of palliative care. For many physicians, palliative care is equal to end-of-life care: an intervention that should be implemented only with terminal patients who are no longer candidates for treatments that affect the course of their disease. Interestingly, their belief is closer to the concept of hospice than to palliative care, so we need to take a step back and look at some background and history. By doing so, we will not only realize that palliative care should be part of early interventions, but also that many primary care physicians and specialists already practice palliative care.

The word *palliative* comes from the Latin *pallium,* meaning "cloak," as for comfort. Physicians for centuries have provided comfort to the ill, particularly before the advent of sophisticated medical and surgical treatments. If we look at the modern institutional evolution of hospice and palliative care, however, hospice started first. Modern hospice was founded in the United Kingdom in 1967, when Dame Cicely Saunders created St. Christopher's Hospice. The first hospice in the United States was founded in 1974, and in 1986 the federal government introduced hospice benefits. Modern palliative care developed from services provided by hospice physicians and nurses, but it is now mostly independent from hospice.

Dr. Elia is medical director of palliative care services at Marin General Hospital.

According to the World Health Organization, "Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual."[1] The WHO goes on to say that palliative care:

- Uses a team approach to address the needs of patients and their families.
- Will enhance quality of life, and may also positively influence the course of illness.
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy.

In 2012, the American Society of Clinical Oncology (ASCO) concluded that, "Combined standard oncology care and palliative care should be considered early in the course of illness for any patient with metastatic cancer and/or high symptom burden."[2] Their conclusion was the result of a comprehensive literature review demonstrating that palliative care intervention improves symptoms, quality of life and patient satisfaction, and that it reduces caregiver burden.

One of the reports reviewed by the ASCO was a prospective randomized study conducted in 151 patients with non-small-cell lung cancer.[3] One study group received routine oncology care, and the other received both palliative care and routine care. The researchers found that the group receiving palliative care had better quality of life and fewer patients with symptoms of depression. More surprisingly and unexpectedly, patients who received palliative care lived longer despite receiving less aggressive treatment. Median survival for the palliative group was 11.6 months, vs. 8.9 months for the routine oncology group.

In this study, palliative care intervention was associated with less aggressive treatment, longer survival, better quality of life and less depression. Who would not want that for our patients?

Palliative care is a team approach that addresses physical, psychosocial and spiritual suffering in seriously ill patients. Palliative medicine specialists are trained in managing pain,

nausea/vomiting, dyspnea, delirium, constipation and wounds, among other conditions. They are also experts in communication skills, such as those needed for breaking bad news and resolving conflicts between patients, families and healthcare teams. The palliative team also coordinates care when many consultants are involved and families become confused with medical terms, diagnostic tests and therapies to the point that they lose sight of the "big picture." Palliative specialists also provide support for the healthcare team and defuse tensions in emotionally charged situations.

Basic pain and symptom management and communication skills are in the toolbox of any physician, particularly in primary care; family physicians and internists have used these skills for decades. But when symptoms become complex, or when patients experience new symptoms from the drugs they are taking, a palliative specialist's evaluation is indicated. Palliative specialists, for example, often see patients who experience neurotoxicity from opioids. This condition is caused by opioid metabolites and is manifested by increasing excitatory effects on the central nervous system. Patients experience myoclonus, irritability, sleeping disturbances and allodynia. Yes, this is an instance when opioids actually cause pain! And it is a situation that is hard to detect and manage.

The trans-disciplinary palliative team approach also includes skills that are beyond the strictly medical, like evaluating and managing psychosocial and spiritual issues. These additional resources make palliative care an excellent complement to the traditional care provided by physicians and nurses.

Under the newly implemented Affordable Care Act, accountable care organizations will be monitoring metrics of quality and efficiency to implement good medicine that is also cost-efficient. The next few years will also bring a shift of focus from "volume" to "value." The new system will reward cost savings only if supported by good quality performance. It will also look at readmission rates for CHF and COPD patients and optimization of diagnostic tests and interventions in chronic diseases.

In this new context, palliative care can help coordinate care, optimize symptom management and improve patient well-being. The palliative team can also honor patient and family wishes by discussing them in the appropriate environment at the appropriate time—not in the chaos of an emergency room where symptoms and emotions run out of control. The palliative approach can reduce the burden of decision-making for families and decrease interventions that many patients do not want. Palliative care can also play an active role beyond the confines of hospitals. There are already many examples of outpatient and homecare services that allow the palliative team to follow patients after discharge.

Palliative care has been around in different forms for centuries and has evolved into a service that can address suffering at many levels. It has the potential to make our healthcare system more patient- and family-centered and more efficient. It can also bring psychosocial and spiritual dimensions back into medicine.

As to the patient in Room 11 of the ICU, she was eventually seen by the palliative care team, which helped her through that difficult time, as it has done for so many other patients before and since. Some of those patients are back to their normal life; some have left this earth in peace. ◇

Email: eliag@maringeneral.org

References

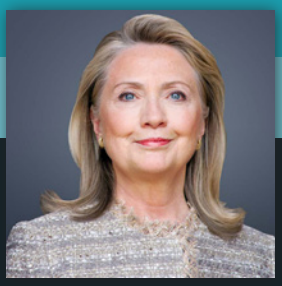
1. World Health Organization, "WHO definition of palliative care," www.who.int/cancer/palliative/definition/en/ (2014).
2. Smith TJ, et al, "ASCO provisional clinical opinion: integration of palliative care into standard oncology care," *J Clin Oncol*, 30:880-887 (2012).
3. Temel JS, et al, "Early palliative care for patients with metastatic non-small-cell lung cancer," *NEJM*, 363:733-742 (2010).

17TH ANNUAL

WESTERN HEALTH CARE LEADERSHIP ACADEMY

PREPARE FOR CHANGE • LEARN PROVEN STRATEGIES FOR SUCCESS • NETWORK WITH COLLEAGUES

APRIL 11-13, 2014 • SAN DIEGO, CA • CONVENTION CENTER



KEYNOTE ADDRESS BY FORMER SECRETARY OF STATE HILLARY RODHAM CLINTON

Aerial photo courtesy of: Corporate Helicopters

TOP THINKERS AND DOERS SHARE STRATEGIES AND RESOURCES FOR ACCELERATING THE SHIFT TO A MORE INTEGRATED, HIGH PERFORMING AND SUSTAINABLE HEALTH CARE SYSTEM.

THE CONFERENCE WILL EXAMINE THE MOST SIGNIFICANT CHALLENGES FACING HEALTH CARE TODAY AND PRESENT PROVEN MODELS AND INNOVATIVE APPROACHES TO TRANSFORM YOUR ORGANIZATION'S CARE DELIVERY AND BUSINESS PRACTICES.

WESTERNLEADERSHIPACADEMY.COM

WESTERN HEALTH CARE LEADERSHIP ACADEMY

CMA California Medical Association

CMA FOUNDATION

MGMA Medical Group Management Association California

A Multidisciplinary Approach to Managing Delirium

Wendy Eberhardt, MD, and Clay Angel, MD

More than 7 million hospitalized Americans suffer from delirium each year, and more than 60% of these cases aren't recognized by the healthcare system. The delirium population suffers higher mortality, longer hospital lengths of stay, more discharges to long-term care settings, and a higher probability of developing dementia at 48 months. Hospital delirium is a particularly big problem for fragile elderly patients.

Beginning in September 2010, a multidisciplinary team at Kaiser Permanente San Rafael began applying industry best practices to manage delirium in our hospitalized medical-surgical population. When the program started, our experience and data were similar to national averages. Approximately 20% of patients admitted to our med-surg floor experienced some degree of delirium, and the reported ICU incidence of delirium often approached 80%. By anticipating the development of delirium in high-risk populations and implementing proactive approaches to prevention and management, we have significantly reduced these numbers.

Dr. Eberhardt, a geriatric psychiatrist, and Dr. Angel, a hospitalist, are on staff at Kaiser Permanente San Rafael.

The most compelling argument for the success of the program is a 23% reduction in average length of stay for patients with a diagnosis of delirium, which translates to an estimated $2.4 million annual savings in direct hospital expenses. Our delirium program has been recognized as a best practice, and elements of its model of care are being adopted at other Kaiser Permanente facilities across the country.

What is delirium? The term describes a new state of confusion and disorientation that has a medical cause. While "delirium" is often confused with "dementia," the former can be distinguished as an acute state of confusion characterized by inattention, abnormal level of consciousness, disorganized thinking, and a fluctuating course. Only in the past couple of years has evidence accumulated that delirium may be associated with outpourings of dopamine, although other neurotransmitter abnormalities have also been implicated. But delirium remains a condition that is identified by observation.

Providers often have difficulty identifying delirium because it has an acute onset and a fluctuating course. In the hospital setting, delirium can appear as:

- Trouble paying attention.
- Asking the same question over and over again.
- Forgetfulness and confusion about time or place.
- Terrifying hallucinations: seeing, hearing, or feeling things that are not there.
- Sudden changes in emotions.
- Agitation, which may include trying to remove dressings, tubes, Foley catheters and other items.
- Excessive sleepiness that fluctuates with periods of agitation.
- Trouble sleeping

In designing our delirium program, we recognized the importance of using a multidisciplinary team to implement early interventions aimed at reducing the severity of symptoms. We also implemented more effective use of relevant protocols, order sets and medications, as well as comprehensive staff education.

Treatment for delirium can be conceptualized as a multimodal approach that includes environmental, behavioral and medical treatment, along with medication management of symptoms. Helpful methods to reduce the effects of delirium include:

- Train all hospital staff to recognize and appropriately approach the delirious patient.
- Identify and assess at-risk patients in their first hospital day. Our team uses the CAM-ICU assessment tool.
- Provide an environment of stability: avoid moving patients to other rooms, minimize catheters and IVs, avoid agitating TV shows.
- Address cognitive impairment or disorientation by providing appropriate lighting and clear signage. Explain

where the patients are, who they are, and what your role is. Introduce activities and facilitate regular visits from family and friends.

- Address dehydration, poor nutrition and constipation.
- Assess for hypoxia and optimize oxygen saturation.
- Encourage mobility by carrying out active, range-of-motion exercises and walking, if possible.
- Address sensory impairment: attend to impacted ear wax, and ensure that hearing and visual aids are available.
- Assess and treat pain.
- Look for and treat underlying infections.
- Carry out a medication review, taking into account both the type and number of medications.
- Promote good sleep hygiene by avoiding nursing, medical procedures and noise during sleeping hours.

After the underlying medical conditions causing delirium are treated, and when behavioral and environmental approaches are unsuccessful for managing symptoms, we use pharmacologic interventions. There are no FDA-approved drugs to treat delirium, but antipsychotic medications are the standard of care.

Quetiapine, olanzapine, risperidone and haloperidol can be effective for psychotic symptoms. Choice of agent is often influenced by route of administration and the severity of the behavior being treated, such as verbal and physical aggression vs. milder symptoms of paranoia, restlessness and anxiety. The beneficial side effects of these medications should also be considered. For example, the sedating effects of Seroquel can be useful for a patient who is up all night.

In refractory and specific cases, valproic acid and benzodiazepines can be used. We make every effort to teach providers about the negative effects of benzodiazepines. There is a role for these medications, but they must be carefully monitored and titrated. In these cases, the expertise of our clinical liaison psychiatrist is critically important.

Managing delirium has been likened to pain management. For each 24-hour period, required doses of medication that are needed to manage behavior are added up and then scheduled the following day in divided doses. As the delirium clears, medications are tapered off.

We strive to be a restraint-free facility, and we only use restraints when absolutely necessary. Sitters who are trained in managing and interacting with the fragile elderly are preferred because restraints often increase delirium.

We have found in the spread of our delirium work that a story can often best highlight what can go wrong and why delirium management takes a multidisciplinary approach. Delirium must be taken seriously and recognized quickly and early in a patient's clinical course.

In the following story, we will call our patient CW. Identifying factors and specific details have been changed to protect patient identity.

CW was admitted to our medicine service with a COPD exacerbation. He seemed like a standard pulmonary patient with an unremarkable medical history other than degenerative joint disease and osteoarthritis. He was a charming man in his early 70s; he loved fishing and spending time outdoors.

The admission sign-out seemed straightforward: antibiotics, steroids, breathing treatments, pain meds and a possible CT scan if he wasn't better by the next day. The admitting physician remembered telling his colleague, "This will be easy. Should be a few days max."

CW's stay lasted nearly three months.

The week following admission, CW wasn't improving as we had expected. A CT scan showed significant lung disease and a possible abscess. Staff performed a thoracoscopic procedure and placed CW in the ICU for observation, at which point he was noted to be a little confused.

CW was in the ICU for weeks. Treatment involved restraints, IV drips, lap

Protect the ones you love...

Give the Gift of Lifeline®

Support independent living with 24-hour a day emergency assistance at the press of a button.

- *Local & personal*
- *No long-term contracts*
- *FDA approved*
- *No equipment to buy*

LIFELINE OF THE NORTH BAY
A service of the Petaluma Health Care District
Serving 6 counties

For more information on the leading personal medical response service for more than 40-years call:

(707) 778-7883
(800) 949-2434
www.lifelinenorthbay.com

belts, Ativan, Haldol and sitters. He was eventually transferred to a med-surg bed with a 24-hour sitter. We did the best we could on the med-surg unit, but most of the time, CW thought he was in a casino and that it was sometime in the late 1980s. One evening, while walking around the unit with a sitter, he suddenly broke away, ran for a nearby exit door, and fell down a flight of stairs.

Code blue. STAT head CT. Intracerebral bleed, luckily non-surgical, Another month in the ICU …

After a long and difficult journey, CW finally transferred to a nursing facility and went home shortly thereafter. His story does not end there, however. Several months later, he presented to the ER with another COPD exacerbation. We had no tools or interventions in place for delirium at that time. He received steroids that night, along with a quinolone antibiotic. Guess what happened? Within six hours of admission, he was acutely delirious. But, this time it only took about 15 days for him to clear mentally and go home.

One year later, CW was electively admitted for a surgical procedure. By this time, we had basic protocols in place and assessment tools for delirium. We also knew which meds not to give, especially steroids. We kept his room as quiet as possible, used Trazodone instead of Ambien when he wanted a sleeping pill, and didn't move him from room to room. He was out of the hospital in three days—without ever developing delirium. He was admitted again for another elective surgery a few months later with the same result: in and out.

Delirium management can be like trying to avoid a head-on collision during a car accident. When CW first arrived at our hospital, we all suffered a head-on collision. On the second presentation, it was more of a side-swipe. On the third and fourth admissions, we avoided a collision altogether.

A team approach and a stage 7 electronic medical record system are absolutely necessary to ensure success in a multidisciplinary, integrated delirium treatment program. We believe that Kaiser Permanente is on the forefront of delirium management because of these two points. With the technology we have in place, we can see real-time medication lists, lab trends and behavior assessments. This allows us to implement protocols and standardized order-sets that ensure a more consistent approach, without a specific expert being present.

We have enjoyed building our program and seeing our educational efforts and multidisciplinary approach yield results that improve outcomes for our patients and their families. The beauty and satisfaction in delirium management is that most of these fragile patients can be managed with simple, cost-effective, non-pharmacologic interventions. We have seen first-hand that they work. ◇

Emails: wendy.x.eberhardt@kp.org, clay.angel@kp.org

For expert care and compassionate support, call California's oldest hospice

Hospice by the Bay

We're your most experienced partner for

- hospice care
- pediatric palliative care
- in-patient palliative consultation
- grief counseling

Call us for admissions 24/7, including evenings and weekends

(888) 720.2111

Connect with us from your smartphone or tablet

Download our mobile app to find everything you need to make patient referrals, including hospice diagnosis and eligibility criteria. Then securely sign and send us your referrals or requests for medical director consultations or patient evaluations.

Visit our *Health Professionals* section at www.hospicebythebay.org to download the app and our guide, *Is It Time for Hospice?*

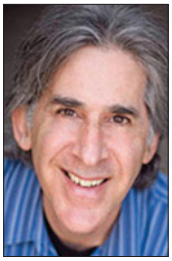
Improving Health Literacy in Older Patients

Daniel Jay Sonkin, PhD

Older adults are a rapidly growing population in the United States, and a significant percentage of them experience acute and chronic illness. To prevent complications, these older patients need to recall important health information, accurately report their symptoms, observe their progress, report those observations, manage their condition, and stay informed. The most important factor in restoring health is to accurately and consistently follow medical directives. These and other skills have been correlated with positive treatment outcomes, sustained health, and collaborative relationships with healthcare professionals.

For older adults, however, the need for these abilities occurs within the context of a decline in cognitive functions that typically begins in midlife and may continue to fluctuate at various rates through the end of life. Mild declines in cognition may include:

- Walking into a room and forgetting what you were looking for.
- Being interrupted during a task and forgetting the original task.



Dr. Sonkin, a marriage and family therapist in Sausalito, administers Cogmed Working Memory Training to adults experiencing mild to moderate deficits in working memory.

- Forgetting the names of colleagues.
- Not being able to memorize a phone number long enough to dial.

We often refer to these examples as "senior moments." If the decline begins to affect healthcare management, however, the consequences can be devastating. Coping strategies and, in some cases, intervention become necessary to minimize the risk for complications.

More serious evidence of memory decline in a medical setting includes:

- Forgetting to take medication or the correct dosage or at the correct time.
- Forgetting your diagnosis or the reason for an appointment.
- Forgetting medical directives, such as medical interventions and lifestyle changes.
- Forgetting medical appointments.
- Forgetting or being unable to explain a condition to others.
- Forgetting symptoms.

The decline in one particular cognitive function—working memory—has a strong relationship to health literacy. "Working memory" has been defined as the amount of information we can hold in our minds to complete a task.[1] This type of memory allows us to store immediate experiences and a little bit of knowledge. However, if we don't do anything with that information, it is likely to be forgotten.

Neuropsychologists use the term "manipulation" to describe one of the mental processes that allows material in working memory to become stored in short- or long-term memory. Manipulation typically involves reaching back into our long-term memory (things we already know), bringing out that information, and mixing it with new information. Long-term memory allows us to process working memory in light of our current goal or what's happening at the moment, such as listening to our physician tell us our diagnosis and the proposed treatment plan. Novel information is always more difficult to process than familiar information.

Working-memory capacity is the way we take what we already know and what we can hold onto in our working memory to satisfy our current goals. People with high working-memory capacity:

- Tend to be good story tellers.
- Do well on standardized tests.
- Have high-level writing skills.
- Have excellent reasoning abilities.
- Are particularly good at problem solving.
- Are good at completing practical tasks.

But even people with good working memory will experience mild decline as they age. Others may experience a greater decline, which can interfere with health literacy.

Navigating today's healthcare system takes tremendous mental and physical energy. When experiencing an acute or chronic illness, patients are bombarded with new information, and the demand for quickly learning and processing unfamiliar information is very high. When confronted with their own health crises, even health professionals must exert incredible emotional and cognitive resources in response to their health needs. This response often needs to be accomplished when you feel physically uncomfortable or impaired.

Health literacy has been described as a set of skills that allow patients to engage effectively in the healthcare encounter, including treatment.[2] These skills allow patients to:

- Take in and remember medical directives.
- Act on medical directives outside the physician's office.
- Recognize when interventions result in improvement.
- Identify negative side effects or declining condition.
- Know when to seek medical attention.
- Know how to self-manage mild symptoms.

Health literacy is affected by a variety of factors, including emotional, cognitive, economic and social stressors, age, language, ethnicity, education and specific personality factors. High health literacy has been correlated with positive treatment outcomes, particularly when the outcome is heavily dependent on patient compliance. Health literacy is particularly important in conditions where the patient is actively involved in the treatment process, whether that involves the use of medication, a medical device, or requiring lifestyle changes.

There are various formal and informal ways a healthcare professional can assess health literacy,[3] but the more important approach is for the physician to create a welcoming and supportive environment that is conducive to helping patients with low health literacy. Being a good observer of human behavior can be an asset. One researcher, for example, found that the patient's speed in signing their name was positively correlated to health literacy (faster speed, higher literacy).[4]

At some point, it may be necessary to refer a patient for cognitive rehabilitation. Many claims have been made as to the efficacy of brain-training programs. There are scores of studies documenting how cognitive abilities can be changed through various interventions. In the most recent meta-analysis of working-memory training programs, researchers found mixed results.[5] Among their findings:

- The outcomes of any particular program depended on the population being studied, the structure of the training program and the research methodology.
- Programs that didn't include training support (such as coaching) were less effective due to high incompletion rates.
- Children under 10 and adults over 60 were found to have better outcomes than older children and younger adults.
- Personality factors also played into outcome. For example, subjects scoring high in conscientiousness showed greater improvement than less conscientious participants.

The question is not so much whether brain-training programs are effective, but rather whether someone is a good candidate for a particular type of training program. To maximize effectiveness, physicians who are contemplating making such a referral need to develop a relationship with their providers so they can refer patients who are a good fit.

As mentioned earlier, using prior knowledge encoded in long-term memory is critical to leveraging working memory capacity. To improve health literacy, physicians who present new data need to help patients connect novel information with their current knowledge. Doing so will increase the likelihood of manipulating the data so that it sticks.

Research supports the thesis that prior knowledge supports comprehension.[6] Likewise, a growing body of research suggests that working-memory capacity specifically increases health literacy among older adults, particularly as it relates to medication adherence.[7] It makes intuitive sense that leveraging working-memory capacity would increase learning and therefore health literacy.

Below are guidelines that may contribute to increased health literacy within the context of working-memory deficits. As already mentioned, the first step to improving health literacy is to create an environment that is conducive to increased patient learning. This is not always easy in today's busy healthcare environment. The goal is not perfection, but doing whatever is possible given the constraints of your particular environment.

- When imparting health directives, look at the patient so you can receive important nonverbal information that may be indicative of information overload or a lack of understanding. Noticing the patient's face during conversation can be quite revealing. If the patient looks confused or their eyes are beginning to glaze over, you may need to slow down.
- The physician or an assistant may need to spend additional time with the patient to make sure they understand directives and/or treatment recommendations. Encouraging assistants to ask the patient questions to determine if they understand the instructions being communicated.
- Helping the patient link new information to already acquired knowledge (available in their medical history) is critical to helping them use their working memory capacity to its fullest extent.
- Write down all medical directives and information necessary for compliance. Auditory communication alone is the least optimal mechanism for learning; visual and auditory together is the best. (See the sidebar on the next page for specific recommendations about using text and images.)
- Remember that risk information is processed both cognitively and emotionally. Patients may need to discuss their fears about the risks associated with a particular intervention.
- Visualizing helps people remember.

For example, ask a patient to tell you where they keep their medications. Then have them imagine going to that place, opening up the container and taking their medication with a glass of water. Just going through that process can help to consolidate information into short-and long-term memory.

• Have a patient's relative or friend present at the appointment.

• Multimedia can be useful for increasing health literacy, but retention will be greater if there is an opportunity to process the information afterward with a healthcare professional.

• Smartphone apps can improve health literacy. Some of the more common apps are used to monitor chronic illnesses such as hypertension, diabetes, depression and anxiety. Others help with lifestyle management issues such as diet, sleep and stress management. ◇

When using text to communicate with patients:

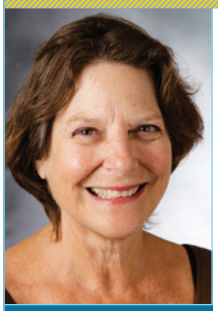
- Avoid using technical jargon.
- Try not to use handwriting unless it is very legible.
- In printed text, use a clear simple font and avoid visual clutter.
- Use lists instead of paragraphs.
- Group information into meaningful chunks of a reasonable size so as to avoid information overload.
- Use headings to organize the information and let readers know what they are about to read.
- Use pictures to augment the written or spoken word. There is evidence that visual images can enhance health literacy.[8]

Email: contact@danielsonkin.com
Website: www.danielsonkin.com

References

1. Klingberg T, "Training and plasticity of working memory," *Trends Cog Sci,* 14:317-324 (2010).
2. Cornett S, "Assessing and addressing health literacy," *Online J Issues in Nursing,* 14;3 (2009).
3. Wallston KA, et al, "Psychometric properties of the Brief Health Literacy Screen in clinical practice," *J Gen Int Med,* 29:119-126 (2014).
4. Lindau S, "Growing evidence for 'time to sign.'" *Pat Edu & Counsel,* 93:667 (2013).
5. Melby-Lervåg M., Hulme C, "Is working memory training effective?" *Dev Psych,* 49:270 (2013).
6. Hambrick DZ, "Why are some people more knowledgeable than others?" *Mem & Cog,* 31:902-917 (2003).
7. Insel K, et al, "Executive function, working memory, and medication adherence among older adults," *J Gerontology Series B,* 61:P102-107 (2006).
8. Houts PS, et al, "Role of pictures in improving health communication," *Pat Edu & Counsel,* 61:173-190 (2006).

The Altschuler Center for Weight Loss & Wellness



Gail Altschuler, MD
MEDICAL DIRECTOR

A 10% Weight Loss Lowers Diabetes Risk By 58%

Obesity is an epidemic affecting almost 40% of Americans. And a 10% weight loss lowers diabetes risk by 58%. Do you observe illness related to obesity but lack the time to address its complex issues? I specialize in weight loss for a simple reason. Weight loss effectively addresses conditions like diabetes. Your new and pre-diabetic patient referrals ensure them the best treatment medicine can provide.

(415) 897-9800
GREENBRAE • NOVATO
www.MarinWeightLoss.com

The Altschuler Center for Weight Loss & Wellness

Personalized Medical Care
. . . at a cost that won't hurt.

MEDICAL CENTER OF MARIN

Get to know us at MCoM . . .
we're right in your neighborhood!

415-924-4525

Prompt, Caring, Personalized Medical Care

Medical Center of Marin is an urgent care clinic located in Corte Madera just off Highway 101. We offer minimal wait time, personalized walk-in-service, at a cost that is far less than an emergency room visit.

We work directly with physicians, serving their patients quickly and sending them back to the referring physician for follow-up treatment.

All but life-threatening injuries can be treated at our locally owned and managed clinic. We have been dedicated to serving the community of Marin for the last 25 years.

+ Pediatric Patients Welcome
+ Digital Radiology Suite
+ Respiratory Illnessess
+ Allergies and Asthma
+ Sprains and Strains
+ Walk-ins Welcome/Appts. Available
+ Ear and Eye Infections
+ Gynecological Ailments/UTI/Lab Tests

www.mcomarin.com

101 Casa Buena Drive
Corte Madera, CA 94925

Monday–Friday from 9am to 6pm
Saturday from 10am to 2pm

The Power of CMA Membership

Why Join Today?

- CMA, representing 40,000 physicians, influences public policy at the federal and state level.
- Join today to activate your personal web account at www.cmanet.org
- CMA is only a phone call away! Our live-person call center is available Mon-Fri during business hours at 800-786-4262.

"If you aren't at the table, you're on the menu…"

- In the world of politics, having a seat at the table can make all the difference. Here in California, no other advocacy organization commands a similar level of respect in the state capitol as CMA. In 2013, our CEO, Dustin Corcoran, was named number 16 on Capitol Weekly's list of top political power players, a list that has featured his name every year since 2009.
- Understanding the mutually beneficial relationship that can exist between organized medicine and medical groups, several key names in California's health care industry have joined CMA, dramatically altering the association's membership. These shifting membership trends are evidenced in recent policy enacted by CMA's House of Delegates, which contains a strong delegation from medium and large medical groups.
- Recent additions to the association include Mercy Medical Group in Sacramento and Loma Linda University's Faculty Medical Group, while other partners such as The Permanente Medical Group, the Palo Alto Foundation Medical Group and the Sharp Rees-Stealy Medical Group have long-standing membership commitments to CMA.

A major player in health care's top issues

- CMA continues to be the leading advocate for bolstering the state's Medi-Cal program. In a world where shrinking reimbursement payments are now being viewed as the norm, CMA has fought costly cuts to the state's Medi-Cal program, and is currently sponsoring legislation that would restore the 10 percent cut to Medi-Cal provider reimbursement rates that was enacted as part of the 2011 State Budget Act.
- CMA has also been the most ardent defender of California's Medical Injury Compensation Reform Act (MICRA), one of the nation's most important examples of tort reform. CMA is currently a leading partner in a coalition assembled to defeat a proposed anti-MICRA ballot measure, Patients and Providers to Protect Access and Contain Health Costs.
- Through aggressive legislative and regulatory advocacy, CMA has positioned itself as one of the most vocal stakeholders in the state's implementation of the Affordable Care Act (ACA). A regular presence at meetings of Covered California's Board of Directors, CMA staff continues to advocate on behalf of physicians as the landmark legislation becomes a reality.

A commitment to public health

- CMA's sponsored bill package also routinely includes legislation aimed at improving public health. Recent examples include bills to advance immunization in California through education and greater access. Additionally, CMA has looked to decrease obesity in children by removing sugary beverages from school campuses and is currently sponsoring legislation to place warning labels on sugar-sweetened beverages.

For more information about CMA and its programs visit www.cmanet.org

CMA Envisions a New Future for Organized Medicine

Steven Larson, MD, MPH

Change is never easy, but oftentimes it is necessary, and even invigorating. The California Medical Association (CMA) is about to embark on a journey of change that will position our association as a nimble, proactive organization ready to lead the practice of medicine into a brave new world. In 2013, the CMA House of Delegates (HOD) approved a plan to reform the way our association is governed. Will it be easy? No. Will it be worth it? There is not a doubt in my mind.

In a nutshell, the reforms will make CMA more relevant and effective by focusing the association on, and bolstering its resources to address, the critical issues of universal importance to physicians. By doing so, CMA will be better able to protect the interests of its physician members and, even more important, guide the future of our profession, not only in California but nationwide.

For more than 150 years, CMA has been guided by the HOD, which meets once a year to set policies and direct resource allocation. This structure has led to a sometimes unwieldy 581-member HOD, a board of trustees numbering more than 50, a seven-member executive committee, and hundreds of other members serving as alternate delegates and in various capacities on dozens of councils, committees, sections and mode-of-practice forums.

Dr. Larson, a Riverside internist and infectious-disease specialist, chairs the CMA board of trustees.

A proposal to reform CMA's governing structure, put before the HOD this past October, proposed that instead of a diffuse focus on many issues, the HOD take on a limited number of big issues: the most important, most pressing matters facing physicians and the practice of medicine.

CMA's long-standing traditions of democratic participation and representative governance would continue. The difference, as envisioned by the GTAC, is that specific issues that are of concern to a narrow spectrum of the membership would no longer command HOD's limited time. Rather, the democratically elected board of trustees would act on those issues, as it already does on the increasing number of matters referred to the board for action by an HOD that is aware of its policy-making constraints.

The HOD would continue to set policy on major issues, and its decisions would be informed through a year-round process not constrained by 15-minute limits on debate of recommendations developed in a rushed overnight exercise, as is currently the case. More focused expertise would be brought to bear in a more careful development of recommendations for action. Policy on other issues would realize the same benefits of a more careful and expert deliberative process throughout the year.

We would like to improve the discussion at the HOD to deal with the big issues of the day and to use the valuable resources of our delegates for the collective development and direction of important policy matters. We believe this proposal has real potential for a robust discussion around issues that will impact all physicians.

The reforms would also open the discussion to individual members who could continue to bring forth their ideas and proposals through a year-round resolution process provided for in the CMA bylaws. Such proposals would be studied, with recommendations acted on by the board. A year-round dialog about timely issues should result in well-thought-out policy pieces that could be brought to the floor during HOD.

Last year's discussion and debate at the HOD on governance reform has set the stage for the GTAC to make proposals to modify the bylaws to begin the changes needed to set CMA's course for the next 150 years.

I am optimistic that this will result in an improvement for our entire organization. It will make CMA more effective in reaching the average member and give them a direct voice in policy, bringing broader input into our more difficult decisions. ◇

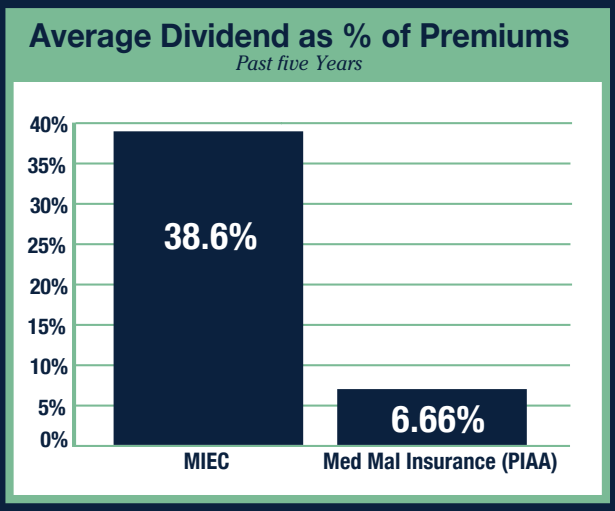
The full report of the CMA Governance Technical Advisory Committee, as amended by the HOD in October 2013, is available for download to CMA members only at www.cmanet.org/hod. Click on the Documents tab; the report begins on page 12 of the "Actions of the 2013 House of Delegates" document.

" I am thrilled to work at MIEC - a company that shares my philosophy of integrity and compassion towards policyholders."

Underwriter
Nina Salvino

Service and Value

MIEC takes pride in both. For nearly 40 years now, MIEC has been steadfast in our protection of California physicians. With conscientious Underwriting, excellent Claims management and hands-on Loss Prevention services, we've partnered with policyholders to keep premiums low.



Added value:

- No profit motive and low overhead
- 17.5 million in dividends* distributed in 2014

For more information or to apply:

- www.miec.com
- Call 800.227.4527
- Email questions to underwriting@miec.com

* (On premiums at $1/3 million limits. Future dividends cannot be guaranteed.)

MIEC 6250 Claremont Avenue, Oakland, California 94618 • 800-227-4527 • www.miec.com

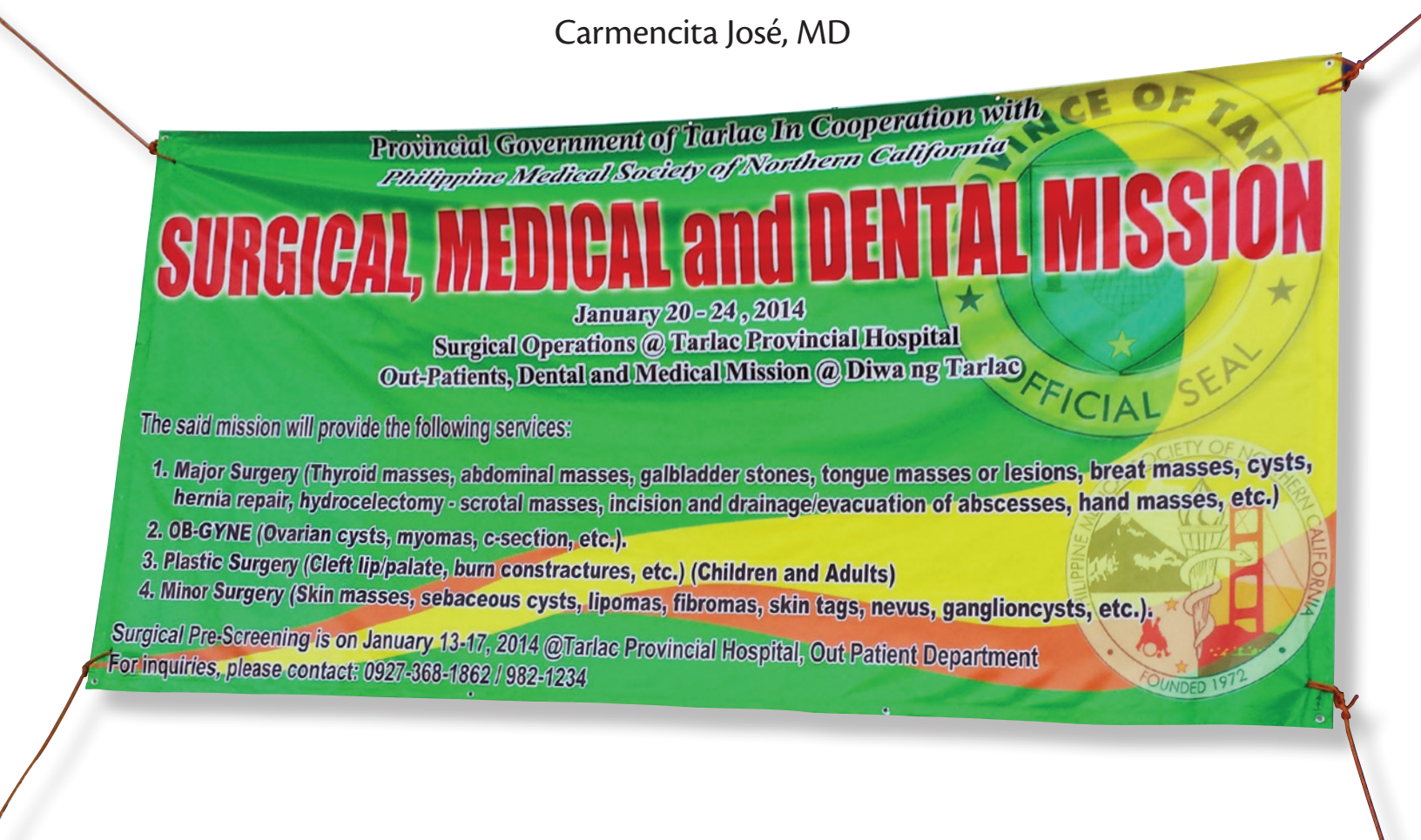
MMS_newsletter_03.07.14

MIEC

Owned by the policyholders we protect.

Report from the Tarlac Medical Mission

Carmencita José, MD


Provincial Government of Tarlac In Cooperation with
Philippine Medical Society of Northern California
SURGICAL, MEDICAL and DENTAL MISSION
January 20 - 24 , 2014
Surgical Operations @ Tarlac Provincial Hospital
Out-Patients, Dental and Medical Mission @ Diwa ng Tarlac
The said mission will provide the following services:
1. Major Surgery (Thyroid masses, abdominal masses, galbladder stones, tongue masses or lesions, breat masses, cysts, hernia repair, hydrocelectomy - scrotal masses, incision and drainage/evacuation of abscesses, hand masses, etc.)
2. OB-GYNE (Ovarian cysts, myomas, c-section, etc.).
3. Plastic Surgery (Cleft lip/palate, burn constractures, etc.) (Children and Adults)
4. Minor Surgery (Skin masses, sebaceous cysts, lipomas, fibromas, skin tags, nevus, ganglioncysts, etc.).
Surgical Pre-Screening is on January 13-17, 2014 @Tarlac Provincial Hospital, Out Patient Department
For inquiries, please contact: 0927-368-1862 / 982-1234
OFFICIAL SEAL
FOUNDED 1972

Note: *On Jan. 20-24, the Philippine Medical Society of Northern California (PMSNC) led a medical mission to Tarlac Province to help victims of Typhoon Haiyan, the deadliest Philippine typhoon on record. The storm, which struck on Nov. 8, 2013, killed more than 6,200 people. The following report by Dr. José is addressed to the 40 physicians and other volunteers who joined the Tarlac Medical Mission.*

Dr. José, a retired Napa psychiatrist and pediatrician, is the medical mission coordinator for the Philippine Medical Society of Northern California.

Many of you have emailed to tell us how fortunate you have been for joining this medical mission.

To these volunteers, we would like to tell you, the pleasure is all ours. Thank you very much for being part of this medical mission to Tarlac Province. Your medical, surgical, dental and prosthetic services have changed lives. Arguably, you have been the most pleasant and giving volunteers that have joined a PMSNC medical mission.

Five thousand patients were seen and treated, but more importantly, more complex surgeries were performed in Tarlac than in any other missions, and these surgeries have drastically changed lives.

This mission covered mostly all the surgical specialties, from general and minor surgery, plastic surgery, ob-gyn, urology and ophthalmology (mainly canalization for glaucoma). Dr. Stephen Post, our ophthalmologist, lectured and trained one of the local ophthalmologists at the Tarlac Eye Center on the surgical management of glaucoma. Finally, as in the past two missions, we again had our human engineer who fitted prosthetics and taught patients how to walk and use their new arms.

Medical volunteers at Tarlac Mission, including Dr. Peter Bretan (far right).

Many people were teary-eyed at seeing a legless person walk again, an armless person hold a pen and write again.

The surgery census was as follows:

- General: 45 surgeries. Triage consult without surgery was 449.
- Orthopedic surgery: 3 major ones.
- Plastic surgery: 28.
- Ob-gyn: 24.
- Minor surgery: 142.
- Ophthalmology: 21, mostly canalization for glaucoma.
- Prosthetics team fitted 55 but including follow-ups saw 105.

The rest of the 5,000 patients were seen in the outpatient clinics, where the dental team served 1,273, pulmonology-respiratory 42, ob-gyn 53, pediatrics 1,100 and primary care-adult medicine 1,715.

Volunteer surgeons came from all over the United States. For the first time in the history of the Tarlac Medical Mission, non-PMSNC volunteer surgeons and anesthesiologists outnumbered PMSNC member surgeons and anesthesiologists. From information received, these nonmember volunteers admired the humanitarian mission that the PMSNC has been doing for the past 29 years and decided to take a look and be a part of these humanitarian endeavors.

Primary care physician volunteers for the mission came from all over California. In addition, Governor Victor Yap of Tarlac, our sponsor, mobilized local health center physicians to help see patients in the outpatient department.

It is gratifying to know that in some token and minute way, the PMSNC medical missions are finally being seen for what they are: helping and making a difference in destitute people's lives. We have the utmost confidence that the PMSNC will thrive even more, with Dr. Carmen Agcaoili as president and Dr. Peter Bretan as president-elect.

The encouragement and support of the PMSNC members who were in Tarlac has been unwavering, with no recompense or prodding. They volunteer their time in the service of the poor and also in honor of the PMSNC, a medical society that they have cherished and loved. In this medical mission, the PMSNC was represented by the following members: Drs. Rey and Marlene Cordero, Dr. Carmen Agcaoili, Dr. Peter Bretan, Drs. Ric and Claire De Leon, Dr. Madeleine Hernandez and Dr. Marlene Salvador. Our personal thanks to all of them. You have represented the PMSNC with vigor and honor.

To all the doctors, dentists, prosthetists, nurses, students and support group, thank you from the bottom of our hearts. You have made our work coordinating this medical mission enjoyable and meaningful.

To Governor Victor Yap, the entire officialdom of the Province of Tarlac, including Vice-Governor Kit Cojuangco, Board Member Christy Angeles, Project Coordinator Gab Hayashi, the governor's office, and others, too many to mention, we speak on behalf of the entire Tarlac Medical Mission Team: thank you for welcoming us with open hearts. We extend our great appreciation to all of Tarlac Province, for giving us the opportunity to help the province's marginalized and poor. This experience will long linger in our collective and individual consciousness.

Thank you. ◇

Email: irwinjose@comcast.net

Raising the Bar for Services to Women, Infants and Children

Sheri Matteo, CNM

Since its return to local control in 2010, Marin General Hospital (MGH) has made delivering patient-centered care a top priority. The enhancements made to its services for women, infants and children, for example, are designed not only to improve quality and safety in perinatal care, labor, delivery and pediatrics, but also to provide all Marin women and families, regardless of insurance status, with greater choice, control and satisfaction while ensuring the best possible outcomes.

In 2011, MGH and the Prima Medical Group launched an innovative new maternity program involving a partnership with local ob-gyns and certified nurse midwives (CNMs). In designing our new system, we consulted national literature and studies on how maternity systems can achieve the highest level of safety, outcomes and patient satisfaction. Two elements found to be essential to safety were having an ob-gyn in the hospital 24/7 as part of the care team during the entire labor and delivery course, and having a full operative and pediatric team available 24/7 for urgently needed operative deliveries.

To achieve high levels of patient satisfaction, we found it was essential to recognize the widely varying needs, preferences and beliefs women have about their birth experiences, and to provide them with more options during their pregnancy. For example, CNMs, who serve as the primary care providers to pregnant women in many highly developed countries, have different educational and training backgrounds and management styles than physicians. The CNM philosophy of care is more suited to the beliefs of some women. Having both physicians and CNMs available 24/7 in the hospital, working together as a team but also independently managing their own patients, allows women to choose the option that best aligns with their personal needs and beliefs.

MGH is the only hospital in Marin or San Francisco counties to provide this option for all women, regardless of insurance status. CNMs and collaborating obstetricians are available in the hospital at any time a patient arrives. Expectant mothers may choose a delivery primarily attended by a midwife or an obstetrician. (According to strict guidelines, the midwives consult, co-manage or transfer care to the obstetrician if high-risk issues develop.) The primary objective is to ensure that all patients have the chance to choose the type of labor and delivery care they want, with the safety afforded by round-the-clock support services such as anesthesia, pediatrics, perinatology and specialized nursing care.

In addition to its use of CNMs, MGH has launched several other initiatives to improve maternity and pediatric care. The hospital has one of the lowest C-section rates in the country, and one of the best VBAC rates, as well. Out of 1,349 births at the hospital last year, the total C-section rate was 23.9%—a figure that includes high-risk pregnancies. The national rate is 31.3%. Even better, NTSV (nulliparous term singleton vertex) births—which are a better gauge of controllable C-section rates because they exclude women who have a higher chance of scheduled C-section due to twins, breech or a previous C-section—are just 20.3%. In addition, the VBAC (vaginal birth after cesarean) rate at MGH for all women with prior C-sections was 29.9%, more than three times the national average.

In keeping with the World Health Organization's Baby Friendly Hospital Initiative, MGH has adopted several new policies, including:

- No elective deliveries prior to 39 weeks, in compliance with Joint Commission standards.
- Delayed bathing and weighing of newborns to accommodate immediate skin-to-skin contact of non-distressed infants, which has been shown to have significant benefits both in maintaining infant body temperature and helping with the initiation of breastfeeding.
- Consistent emphasis in the outpatient and inpatient prenatal programs of the benefits of breastfeeding. MGH has achieved an exceptional 99% breastfeeding initiation rate at discharge.

MGH has pediatric hospitalists

Ms. Matteo, a certified nurse midwife, directs midwifery services for the Prima Medical Group.

available 24/7 and extra support when needed from UC San Francisco. In fact, UCSF and MGH pediatric specialists collaborate to establish best practices, with a multidisciplinary review of all cases to improve care, including a focus on optimal pediatric pain management. MGH participates in the California Perinatal Quality Care Collaborative and adheres to the standards set by California Children's Services for Community Hospitals. Parents can count on having their infant, child or teen appropriately attended by a pediatric specialist.

Finally, MGH has teamed up with UCSF to provide expanded services and expertise for our neonatal and pediatric patients closer to home in the newly founded UCSF Benioff Children's Hospital at Marin General. This collaboration includes UCSF neonatologists onsite at MGH, a prenatal diagnostic center staffed with specialists in high-risk obstetrics, and access to all the resources of a top-ranked children's hospital. It also includes a specialty clinic nearby with experts in pediatric cardiology, gastroenterology, neurology, pulmonology, orthopedics and eating disorders.

Although only a small percentage of mothers and infants require the highest level of care, transfer to UCSF can be accomplished quickly and seamlessly through the established close collaboration of the two institutions. For preterm babies 32 weeks and above, MGH's own Level II neonatal intensive care unit provides advanced care, including such therapies as high-flow nasal cannula for preterm infants, a therapy that is more often found in Level III NICUs.

The programs described above provide the quality assurance Marin families deserve. MGH has all the resources in place to provide both the experience patients want and the expertise they need for optimal labor, delivery and pediatric care. ◇

Email: smatteo@primamedgroup.com

Mindy S. Rosenberg, PhD & Daniel J. Sonkin, PhD
CogMed Certified Coaches for Children, Adolescents & Adults

COGMED Qualified Practice

"An evidence-based program for helping children, adolescents, and adults sustainably improve attention by training their working memory"

(415) 332-6703 • **contact@danielsonkin.com**
www.danielsonkin.com

1994-2014
HIRED HANDS INC.
Homecare
20 years
working with
Bay Area Seniors

Serving Marin, Sonoma and Napa Counties, and now the Tri-Valley. Contact us for a complimentary Care Consultation:
415-884-4343 HiredHandsHomecare.com

Reflections on a Long Career

Paul Alpert, MD

Note: *Dr. Alpert wrote the following letter to friends and colleagues upon his retirement.*

It is with a certain amount of sadness and apprehension that I announce the end of my career in clinical urology. The week of Aug 5th, 2013, will be my last in the urology department, where I started 39 years ago. I will be continuing on in my administrative role as our medical-legal chief, and will begin work on an exciting research project with Dr. Stephen VanDenEeden, an epidemiologist at our Division of Research. I have developed a novel proxy for PSA screening, and we will be looking at Kaiser Permanente Northern California data on our prostate-cancer patients to see if PSA screening in our patient population has decreased prostate cancer-specific mortality rates.

As I leave the world of clinical practice, I find myself reviewing our accomplishments over the last four decades. I came to San Rafael in 1974 after completing a urology residency at UCSF, and then a two-year military obligation at a Regional Air Force Medical Center in Southern California, where I was a staff urologist and chief of pediatric urology. I started as the first urologist at the Kaiser Permanente Medical Center in San Rafael as our new hospital was under construction, seeing patients in rented clinic space we had on Professional Center Parkway, and doing surgery in San Francisco.

Our new hospital opened in 1976, and with this, our growth in Marin County increased dramatically. By 1977 we were large enough to add a second urologist. I was delighted to hire Dr. Tony Eason, who was finishing the UCSF urology program a few years behind me. We were now growing pretty rapidly, much of it in Sonoma County, and in the early 1980s, we opened a small satellite clinic in Santa Rosa, and Tony began staffing the urology clinic there once a week. We soon had enough growth to justify hiring Dr. Gary Nicolaisen, who turned down an academic job at UCSF/San Francisco General to come to San Rafael.

The three of us were then the urology department over the next two decades. We did hire several additional outstanding urologists, but that was to create a new urology department for our medical center in Santa Rosa. The three of us practiced together in an era when there was no subspecialization, and we literally did everything. We did the usual open stone surgery, nephrectomies, prostatectomies, cystectomies, scrotal and testicular surgery, trauma, and urethral reconstruction.

With the arrival of Gary, who had spent a year with Dr. Rob Kahn at UCSF learning the new technique of percutaneous nephrostolithotomy, we embarked on minimally invasive stone surgery. And since Dr. Gene Catollica at Oakland, Dr. Arjan Amar at Walnut Creek, and I were the only urologists around the region with any experience or interest in pediatric urology, we had a large series of children we operated on for everything from hypospadias, UPJ obstruction, horseshoe kidneys with obstructed ureters, vesicoureteral reflux, congenital megaureters, a small series of Wilm's Tumors, and even a rhabdomyosarcoma of the bladder in a 3-year-old, who has since graduated from college. An amazing array of pathology paraded through our medical center.

We also continued to maintain our association with UCSF as clinical faculty with their urology department, working with the UC residents at urology teaching rounds at the San Francisco VA Hospital, and regularly attending UCSF urology grand rounds. Since retirement, Tony has taken on a job with UCSF as clinical supervisor and attending physician at one of the UC resident clinics at the VA once a week, and I plan to continue in my current activities at UCSF.

I have held many positions in San Rafael. In 1977, I officially became a partner in The Permanente Medical Group, and since I now had a department member, was appointed chief of urology. In 1978, Dr. Al White, my first physician-in-chief, appointed me medical-legal chief, a position I continue to hold. In 1981, Dr. Richard Geist became our physician-in-chief and asked me to become the assistant physician-in-chief, a position I held until 2001. Under Richard, I also became our risk manager, headed up the Credentials and Privileges Committee, started a precursor of what would become a facility Ethics Committee, and spent six months as our acting physician-in-chief in 1990, when Richard was in Saudi Arabia for Desert Storm.

We did the first regional urology study in the early 1980s, showing the power of our large patient population

Dr. Alpert retired from his 39-year clinical urology practice at Kaiser Permanente San Rafael in 2013.

Dr. Alpert at work on one of his sculptures.

in studying important clinical questions. Using all our regional urologists, we asked vasectomy candidates who had an orchiopexy for an undescended testis as a young child if they would undergo unilateral vasectomy on the non-operated testis. Our finding was that the vast majority of these patients were azoospermic after unilateral vasectomy, and the remaining few had extremely poor sperm counts of 1-3 million, meaning that orchiopexies done in childhood did not preserve fertility in the operated testes. This finding was independent of the child's age at the time of the original surgery, which ranged from 1 to 10 years.

We also created the prototype for our current Member Physician Satisfaction program in 1985, when Richard asked if I could design a training program for our physicians to improve patient satisfaction. I enlisted the help of my psychologist wife, Dr. Geri Alpert, who had worked with well-known Harvard psychologist Dr. Robert Rosenthal for four years as her mentor and doctoral thesis advisor. We created a 19-item questionnaire aimed at determining a patient's perception of the quality and caring of their physician. The questionnaire was given to patients as they departed the medical center.

We were able to show over a 12-month period that by merely giving these scores back to physicians, and showing them where they placed in their departments and in the medical center, we substantially improved physician performance. The results were so impressive that they were presented to The Permanente Medical Group board of directors, and then to the Kaiser Foundation Hospital board of directors. The project was picked up regionally and expanded into what is now known as the Member Physicians Satisfaction Program. This program continues to generate and document remarkable improvements in member satisfaction with physicians. I am proud to say that San Rafael has led that performance, perhaps because we had a several-year head start on the rest of the region.

When I turned 60 in 2001, I stepped down as chief of urology and assistant physician-in-chief, and cut my schedule down to 3.5 days per week. This schedule allowed me to continue part-time in urology, do my medical-legal job, and still have time for outside things like skiing, doing significant construction and remodeling projects, as well as ballroom dancing, theater, reading and sculpture (see photo). My new schedule should be another step down but will still allow me to be both challenged and productive.

Fortunately, the urology department is in sterling condition. While Tony has been retired for five years and Gary will be retiring in November, we have been building a new department over the last 10 years. We have continued with my original policy of only hiring people who were smarter and better trained than we were, and we leave you with four superbly qualified and trained urologists. ◇

Email: paul.alpert@kp.org

Novato Community Hospital

Ranjit Hundal, MD

Note: *Each issue of Marin Medicine includes a self-reported update from one local hospital or clinic, on a rotating basis.*

I first came to Novato Community Hospital (NCH) in the summer of 2003 to join its hospitalist group. I arrived in the leafy suburbs straight from four years of training in San Francisco, after completing medical school and two years of surgery training in London. I thought I'd only be in Novato for a year or two, but I so enjoyed the hospital, the community it served and my coworkers that I never left. Since 2003 I've been involved in every facet of the hospital and formed the North Bay Hospital Medicine Group in late 2010.

NCH is a beautiful place to work. I enjoy that it is a small hospital where I can get to know every one of my 300 coworkers and identify almost all of them by first name, from the chief administrative officer down. For this reason, I was all the more honored to become chief of staff this year.

With the latest challenges in the health insurance exchange rollout under Obamacare, it's been a tumultuous time for healthcare reform across the country. Here at home, we've also had our own personal challenges and lost important allies. In 2013 we mourned the passing of Dr. Palmer White, who was an instrumental figure in building the new NCH hospital, as well as a gifted general surgeon. We were also saddened to hear of the sudden and unexpected loss of Dr. Robert Van Herick after his recent retirement. Dr. Van Herick was a respected cardiologist both at NCH and in San Francisco.

Despite these changes and challenges, NCH has forged ahead and continued to thrive under new physician and administrator leadership. We have been excited to welcome new chief administrative officer Brian Alexander and a cadre of up-and-coming committee chairs who highlight NCH's strength in a variety of fields. For a Londoner like me, it truly feels like a "changing of the guard."

Under this new administrative leadership and our strong medical staff, NCH was fully accredited last year by the Joint Commission for a three-year period. The Joint Commission also certified the hospital as a Primary Stroke Center. Our program continues to collaborate with California Pacific Medical Center in San Francisco to provide acute telestroke services.

We are proud that HealthGrades presented NCH with its award for Excellence in Patient Experience and Patient Safety in 2013, placing the hospital in the top 5% of acute care facilities nationwide. The NCH emergency department also won the prestigious Press Ganey Guardian of Excellence Award for achieving 95% overall patient satisfaction over the course of a year.

To serve patients even better, our medical staff is participating in the CMS Bundled Payment Joint Replacement Program. NCH is one of just five hospitals in California participating in this unique program, which combines payments for the hospital, physician and provider services during 30-, 60- or 90-day care episodes into a single bundled payment. This bundling results in improved care coordination and patient-outcome monitoring among partnering caregivers. The project, created by Medicare, resonates with NCH's goal to provide high quality and affordable services to the community by strengthening our relationships with physicians and community providers. Six orthopaedic surgeons, along with anesthesiologists and hospitalists, are participating and will submit quality data this year to ensure efficient care and excellent patient outcomes.

Another program at NCH close to my heart is our hospitalist group, which is turning four this year. In the last three years, NCH has established a cohesive group of career hospitalists to provide care to uninsured and underinsured patients who arrive at our emergency room and require hospitalization. The hospitalists have partnered with Hospice by the Bay to formalize our palliative care program, providing end-of-life care for not only dying patients, but also their grieving loved ones. The hospitalist program is yet another example of NCH's commitment to the community and patients in need.

We strive to hold ourselves accountable for outcomes, quality of care, and all aspects of communication with a goal of continuous improvement. The clinical quality statement for the most recent 12 months puts NCH as one of only seven hospitals in the Sutter

Dr. Hundal, a hospitalist, is chief of staff at Novato Community Hospital.

Health system at full performance. Our current sepsis mortality and overall mortality ratio are amongst the lowest in the system.

NCH's high level of patient satisfaction is matched in equal measure by a satisfied physician staff. Our 2013 Physician Satisfaction Survey showed an overall mean score of 85.9, a national rank of 91st percentile, and a regional group rank of 93rd percentile—a marked 13% improvement compared to 2012. Moreover, NCH physicians, evaluating all managerial parameters such as accessibility, communication and responsiveness, ranked its administration at the 95th percentile nationally, also a significant improvement from last year.

For the last three years, NCH has worked hard to improve processes at the hospital by implementing the Quality Delivery System (QDS), a quality improvement project based on the lean manufacturing methodology pioneered by Toyota. At its core, QDS aims to reduce waste within healthcare, which we all know is abundant. It also helps us diminish the massive clinical variations inherent in healthcare and thus make it more affordable and evidence-based. This work flows from the point of view of the patient and what he or she would consider valuable. Our goal is to eliminate mistakes and provide error-free healthcare. To this end, staff members attend five-day QDS workshops, called *kaizens* (the Japanese word for "improvement"), where they dismantle a process, like discharging or transitioning a patient, and then rebuild it in a more efficient way. I myself am a physician lead on the West Bay QDS team. QDS has led to both quality and bottom-line improvements at hospitals like Park Nicollet Methodist Hospital in St. Louis Park, Minnesota, and the famed Virginia Mason Medical Center in Seattle, Washington. We believe QDS will lead to similar success within Sutter Health.

We've also grown efficiency with our biggest project of the last decade—the launch of an electronic health record (EHR) system powered by Epic software. After years of planning, we rolled out our new EHR on Feb. 1—the 16th of 26 rollouts in the Sutter Health system. I worked clinical shifts during the inaugural weekend, and I'm happy to report that the rollout, perhaps not seamless, was smoother than many of us could have ever hoped for. That's in large part thanks to the ample training we received, and to user specialists offering at-the-elbow support throughout the rollout. Change is never easy, but we can now look forward to the EHR improving quality and safety for our patients through better coordination, more standardized work and real-time accuracy.

The future of healthcare in the U.S. looks uncertain with new federal mandates on the horizon, but NCH will continue to grow and evolve. We hope to build on our repertoire of inpatient services by establishing a center of excellence with our orthopaedic joint replacement program. We are also forging stronger relationships with Marin Community Clinics and other quality providers in the community so that we can offer more help to patients in need. The next decade will be challenging for hospitals, but I'm confident that NCH will continue to prosper and serve the people of Marin and Sonoma counties at our beautiful small hospital, a powerhouse of caring. ◇

Email: HundalR@sutterhealth.org

West Marin Pharmacy
Compounded Medications
Allopathic, Ayurvedic, Chinese, Homeopathic remedies sold OTC
- Natural hormones
- Custom thyroid preparations
- Veterinary medications
- Acyclovir chapstick
- Special nail fungus preparation that actually works

Mon–Fri. 10–6, Sat. 10–4
Tel: (415) 663-1121 • Fax: (415) 663-1219
11 4th St, Point Reyes Station CA, 94956
westmarinpharmacy.com

IHM INSTITUTE FOR HEALTH MANAGEMENT
A Medical Clinic / Robert Park, M.D., Medical Director
THE SAFE EFFECTIVE APPROACH TO RAPID AND PERMANENT WEIGHT LOSS
• Medically Supervised • Nutritional Counseling
• Registered Dietician • Long Term Weight Maintenance
715 Southpoint Blvd., Suite C
Petaluma, CA 94954
(707) 778-6019 778-6068 Fax
350 Bon Air Road, Suite 1
Greenbrae, CA 94904
(415) 925-3628

NEW MEMBERS

David Palestrant, MD, Critical Care Medicine, 7 Circle Way, Mill Valley 94941, Univ Arizona 1996

Peter Uzelac, MD, Obstetrics & Gynecology*, Reproductive Endocrinology, 1100 S. Eliseo Dr. #107, Greenbrae 94904, St. George's Univ 1998

Nakul Varshney, MD, Psychiatry*, Armed Forces Med Coll 1983

* = board certified

Well Worth the Time

Jeffrey Weitzman, MD

The Wonder of Aging: A New Approach to Embracing Life After Fifty, by Michael Gurian, 336 pages, Atria Books (2013).

"A very important book." —Daniel G. Amen, MD
THE WONDER OF AGING
A New Approach to Embracing Life After Fifty
MICHAEL GURIAN
New York Times bestselling author of The Wonder of Boys

I usually try to leave my medical background behind when reading a new book, unless of course the subject is medical in nature. In that situation I often find myself making a quick judgment as to the medical accuracy of the subject being discussed, and whether I think the author is qualified to draw accurate conclusions. If not, I will usually not make it past page 50.

I recently stopped reading a book written about future infectious pandemics. I felt the author, who was not a physician or an epidemiologist, was not writing at a level of medical accuracy and complexity that would expand my knowledge and keep me interested. I did not trust the conclusions that seemed to be made more on conjecture than fact. A book is like wine. Why continue to drink it or in this case read it, if is not worth the invested time?

My initial impression after reading the first few pages of *The Wonder of Aging* was not good. Red flag #1: I find it difficult as a physician reader to hear how the author's physician missed a diagnosis that apparently was obvious to others (we all do wish medicine was easy). Red flag #2: anecdotal dietary recommendations to relieve stress. Put those two, albeit short, sections together, and my mind began to drift to my next book or the football game on TV.

If I had stopped reading *The Wonder of Aging* at this point, I would have missed out on a profoundly important book. What kept me going? It did catch my attention that the author, Michael Gurian, has been a longtime practicing therapist of some note; that he has now written 27 books; that his mother was a gerontologist who was friends with Dr. Elisabeth Kübler-Ross (who was often at his dinner table); not to mention that I volunteered to review the book for *Marin Medicine* . . . all this was reason enough to push on. I'm glad I did.

I would say in retrospect, excuse the bias, that a physician would not have been the best person to write this book, contrary to what I have written above. We are experts in anatomy and physiology, but this book is so much more. In addition to looking at the anatomy and physiology of aging, it includes the interplay of family, work, religion, mental health and cultural values.

The book covers many complex issues of aging in a logical, easily understandable fashion. This is a book that can be enjoyed both by physicians and our patients. As I read the book, I could not help but see my patients, my family and myself being described in a unique fashion, with new insight and analysis of the aging process. It's good to read that we are becoming "elders" and not just old.

What is the difference between being an elder and being old? An elder is about being functional, mentoring, working, guiding the younger generation, staying engaged and keeping fit. Our culture does not presently support the routine engagement of elders in our society; it is focused on the young. We've been moved to the side, no longer required—we need to change this. Gurian asks us to, "consider becoming more visible as you age. . . . The world needs you as a person over fifty to guide it and shape it."

Research shows that there are "blue zones" in the world where people live to great ages. In these regions, the elders are highly valued. They are expected to pass on traditions, teach the young, remain engaged with their community—not move to Phoenix or Boca Raton to live in an isolated retirement community.

One of the main themes of the book, presented in the opening chapters, is that aging can be divided into three distinct stages. Stage 1, the age of transformation, runs from approximately 50 to the mid-60s; Stage 2, the

Dr. Weitzman, an emergency physician at Marin General Hospital, serves on the MMS Editorial Board.

age of distinction, from the mid-60s to the late 70s; Stage 3, the age of spiritual completion, from about 80 to 100 and beyond. I found these divisions to be accurate and helpful in understanding the aging process. As Gurian observes, there will be age differences of 2-3 years for each stage, depending on your true physical and mental age vs. your chronologic age.

In Stage 1, the physiologic effects of andropause and menopause begin. This is a time to finally put to rest your feelings of anxiety and move forward as you transform to an elder. In Stage 2, andropause and menopause come to an end. Gurian writes that this is a time to "feel proud of what we have created, nurtured, and been through in life. … What will matter is not your success but your significance. … This 'life that matters' is your legacy." He also notes that retirement should be "only economic, not spiritual."

In Stage 3, your legacy is now defined. Completion does not mean "the end or death." Gurian says it is important to detach from insignificant issues, to bring loved ones close, to reestablish bonds to those estranged, to seek out religion and spirituality if you are so inclined, and to stay active and engaged.

Subsequent chapters analyze "How Men and Women Age Differently," "The Wisdom of Intimate Separateness," and "The Amazing Grandparent Brain." Each chapter is nicely laid out with supporting facts and experiences of the author, his patients, groups he leads, religious figures, research scientists and physicians, each commenting on their research or experiences. I particularly liked the wise commentary of the clergy.

The final chapter is "The Miracle of Dying and Death." Gurian writes that "there is no right way to die, everyone dies in his or her own way." He discusses a "better way—not morally better but experientially better." He covers physician-assisted suicide in Washington State and our right to die as we choose. This section certainly made sense to me. He finishes with a discussion of our fear of abandonment and the anxiety it produces as we approach death.

In summary, I recommend you read this book for yourself and your family and for a better understanding of the aging process of our patients. I have already recommended it to several family members and friends. It will serve many of our patients well to read it themselves. I can see the book being used as a text for a course on aging and as a guide for discussion groups with intimate friends, reviewing together one chapter at a time. This process could establish a group of friends who know intimately how you feel about the last stage of aging and would allow them to be advocates for you if needed.

In retrospect, I am certainly glad I did not put this book down. It was well worth the time to read. I now wonder how many other books I should have finished reading. ◇

Email: jweitzmanmd@gmail.com

The best starting point for elder care.

Drew Ross, founder

CREATIVE COUNSELING
For Elders And Families, Inc.

707-**239-2310** or 707-**762-5433**
www.**CreativeCounseling.org**

Call us for a free consult!

TRACY ZWEIG ASSOCIATES

A REGISTRY & PLACEMENT FIRM

Physicians

Nurse Practitioners ~ Physician Assistants

Locum Tenens ~ Permanent Placement

Voice: 800-919-9141 or 805-641-9141
FAX: 805-641-9143

tzweig@tracyzweig.com
www.tracyzweig.com

CLASSIFIEDS

FOR SALE: SF Boutique-Style Family and On-Call Practice
Average revenue $407,000; very high profit margin. No third-party plans; all cash. Strong growth potential. The practice is approximately half urgent care and half primary care. Real estate also available. Practice Consultants, info@PracticeConsultants.com or 800-576-6935.

PROUD TO SUPPORT THE MARIN MEDICAL SOCIETY

TO TREAT YOUR NEEDS AS OUR OWN

NORCAL Mutual is owned and directed by its physician-policyholders, therefore we promise to treat your individual needs as our own. You can expect caring and personal service, as you are our first priority. For more information contact a NORCAL Mutual broker.

NORCAL MUTUAL™

norcalmutual.com | 800.652.1051

In a Los Angeles radiology practice, a leaking fire suppression system destroyed a $1,000,000 1.5 tesla MRI. Make sure you're covered.

For decades, The Doctors Company has provided the highest-quality medical malpractice insurance. Now, the professionals of The Doctors Company Insurance Services offer the expertise to protect your practice from risks beyond malpractice. From slips and falls to emerging threats in cyber security—and everything in between. We seek out all the best coverage at the most competitive prices. So talk to us today and see how helpful our experts can be in preparing your practice for the risks it faces right now—and those that may be right around the corner.

Call (800) 852-8872 today for a quote or a complimentary insurance assessment.

- Medical Malpractice
- Workers' Compensation
- Health and Disability
- Property and General Liability
- Employment Practices Liability
- Directors and Officers/Management Liability
- Errors and Omissions Liability
- Billing Errors and Omissions Liability

THE DOCTORS COMPANY
Insurance Services

CA License #0677182

www.thedoctors.com/TDCIS